

# Gay and Lesbian Issues and Psychology Review

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Damien W. Riggs

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The Review is a peer-reviewed publication that is available online through the Australian Psychological Society website. Its remit is to encourage research that challenges the stereotypes and assumptions of pathology that have often inhered to research on lesbians and gay men (amongst others). The aim of the Review is thus to facilitate discussion over the direction of lesbian and gay psychology in Australia, and to provide a forum within which academics, practitioners and lay people may publish.

The Review is open to a broad range of material, and especially welcomes research, commentary and reviews that critically evaluate the status quo in regards to lesbian and gay issues. The Review also seeks papers that redress the imbalance that has thus far focused on the issues facing white lesbians and gay men, to the exclusion of other sexual and racial groups. The Review encourages the elaboration of an expansive approach to psychological research on people of a diverse range of sexual and non-gender normative groups.

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# Gay and Lesbian Issues and Psychology Review

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## **GUEST EDITORIAL: MENTAL HEALTH AND LGBT COMMUNITIES**

LYNNE HILLIER, JANE EDWARDS & DAMIEN W. RIGGS

Over the last 15 years, Australian national research has documented higher rates of mental ill-health in LGBT Australians than in the general population. For example, in a study of the sexuality of over 20,000 Australians, reporting same sex attraction was associated with poorer mental health (Smith, Rissel, Richters, Grulich & deVisser, 2003) and the rates of self harm were very high in a study of the sexual health and wellbeing of 1849 same sex attracted youth (Hillier, Turner and Mitchell, 2005). Analysis of the younger cohort (women aged 22-27 years) of the Longitudinal Study of the Health of Australia's Women (McNair, Kavenagh, Agius & Tong, 2003) found that same sex attracted women were significantly more likely than their heterosexual peers to report being depressed and to have attempted suicide over the last 12 months. Finds from a survey project with 1300 Australian men, over half of whom were gay or bisexual, found that twice the number of gay and bisexual men had suicidal thoughts than those who were heterosexual (Abelson, Lambevski, Crawford, Bartos & Kippax, 2006). Finally in a recent study with over 5000 LGBT Australians, the *Private Lives* report (Pitts, Smith, Mitchell & Patel, 2006) also found higher rates of depression and suicide ideation than in equivalent studies of heterosexual adults.

At an international level, data collected in the US as part of the National Survey of Midlife Development similarly suggests that gay and bisexual men are three times more likely to experience depression than heterosexual men (Cochran, Sullivan & Mays, 2003). In the England and Wales, research with 1285 gays, lesbians and bisexual people found very high rates of mental illness (43%) and attempted suicide (31%) (Warner, McKeown, Griffin, Johnson, Ramsay, Cort & King, 2004) and a

US review of the literature on depression confirmed higher rates in LGB populations than in heterosexual populations (Meyer, 2003).

What are we to make of these findings? In explanation, some of these studies found a direct association between homophobic abuse and symptoms of mental ill-health in LGBT adults (Pitts et al., 2006; Warner et al., 2004) and same sex attracted young people (Hillier et al, 2005). Other Australian research conducted with 3039 gay men found that 39% reported experiencing homophobic abuse in the 12 months preceding data collection (van de Ven, Kippax, Crawford, Race & Rodden, 1998). The resulting sense of social exclusion and lack of belonging to mainstream (heterosexual) communities has been found in Australian samples to result in increased rates of depression amongst gay men (McLaren, Jude & McLachlan, 2007).

When research findings like these are released into the community, responses are usually divided (see Hurley, 2007, for a summary of these responses). On the one hand there is often relief expressed that a clear picture of LGBT mental health has been disseminated at the national level and that now perhaps something can be done about the disparities between LGBT and heterosexual communities. On the other hand, there has been an equally strong response suggesting that by providing particular image of LGBT communities we pathologise and marginalise our communities by hanging out 'dirty washing'. Michael Hurley summarises this dilemma associated with promoting research findings as they relate to the mental health of LGBT people where he states that:

...in some social research context, practices

which assume marginality can produce social deficit accounts of the groups being researched, and in the process reinforce the marginalisation of those groups... [Yet] part of the power of 'marginality' is its affective force. It resonates with many people's experience of everyday life, particularly those aspects which feel unfair or which hurt. In that sense marginality enables both political and emotional performativity. One key problem, however, is whether accounts of marginality framed primarily in terms of invisibility, silence, 'hurt' or social neglect actually enable a sufficiently wide-ranging, systematic voicing of the social capacities that are also part of experiences of marginality (2007, p. 160).

Those of us who are interested in researching with LGBT communities are thus faced with a number of dilemmas, not the least of which is that funding is rarely available without a stated problem. In the instance of LGBT mental health we know the problem: We know that our communities are over represented in a range of negative health outcomes and that some of our behaviours are conducive to ill health. However, to avoid a victim-centred or blaming approach we would argue that research needs to take into account at least two factors. The first is that the problem is not the reporting of the association itself, but rather that at times when the association between LGBT people and poor mental health is reported, there is a lack of critique of the causes of poor mental health in LGBT communities, such as wide spread social homophobia.

Second, we know that the majority of LGBT people live happy and fulfilled lives and make important contributions to society, but there is little research that reports on this. Moreover it is possible to document the productive strategies that many in our communities use to keep themselves healthy and happy. For example, Australian research has found that a sense of belonging to gay communities can ameliorate (at least to some degree) feelings of isolation from the broader community and can also encourage or make possible involvement in the broader community (McLaren,

Jude & McLachlan, 2008). Findings such as these are important as they highlight the potential role that gay men play in developing their own supportive communities that to some extent mitigate against the effects of living in homophobic social contexts.

At this time in our history, when antidiscrimination laws and partnership bills are in place in all states, it is important that we carry out research that examines our mental health and wellbeing from new perspectives that allow no room for an un-critiqued association between homosexuality and mental ill health. None of us wants to pathologise the members of our community. However if there is a story to be told, and if by telling the story we are able to inform change at policy and practice levels, we should go ahead. We know that in every discursive field, different truths are produced and shaped and some are stronger truths than others. We also know that strong truths come with power for action. To this end, in this issue of the *Gay and Lesbian Issues in Psychology Review* we present papers that have the potential to work for change by moving the focus to unhealthy environments, by examining the policy and practice of health professionals, and by documenting creative strategies that successfully resist homophobic subject positions.

The first paper in the issue focuses on community as a factor in mental health. US researcher Esther Rothblum explores the complex phenomenon of community through a series of interviews with lesbian and bisexual women and their biological heterosexual sisters. Women were asked whether they perceived their communities to be there for them during times of stress, and also on the converse of that—how much support they were expected to provide when others in their communities experienced stress. She found that lesbians were more likely to be integrated into their communities than bisexual or heterosexual women. High involvement was important for mental health but did involve a cost.

Young people's creativity and the practice of

self care is the focus of the second paper by Hillier, Mitchell and Mulcare. Their research utilises quantitative and qualitative data collected with same sex attracted young people in order to explore the subjects positions promulgated by many Christian religions. The paper uses a Foucauldian discursive approach to examine the ways that Christian discourses productively divide young people from their communities and within themselves with negative mental health impacts. The paper then documents the many resisting strategies that these young people use to reframe negative subject positions into positive healthy ones, especially in regard to God and Christianity. These strategies are innovative and are a testament to the ways that SSA youth are experts in establishing practices of self care.

The third paper by Semp uses interviews with queer staff of Public Mental Health Services (PMHS) in Aotearoa/New Zealand to explore how a Foucauldian discursive approach can help reveal the ways in which various discourses construct heteronormativity within PMHS to produce significant barriers to clinicians identifying queer clients. Semp argues that in different ways, both the medical and psy discourses fail to adequately account for the impact of homonegativity on queer clients, and on the provision of mental health services.

A critique of health policy on gay men's health is the topic of the paper by Adams, Braun and McCreanor. They are interested in the ways that gay men's health is constructed in policy and the ramification that has for change. In particular they ask of the policy documents: Who gets a say in the documents? How is how gay men's health is constructed and what is the role of the medical profession in gay men's health?

The final research paper, by Fell, Mattiske & Riggs, evaluates the effectiveness of a workshop with post graduate clinical psychology students that aims to improve ways of working with LGBT clients. The workshop examined the impact of heteronormativity on psychologi-

cal practice. It aims to assist participants to provide more appropriate and inclusive psychological services to same-sex attracted clients.

The issue also includes two commentary papers. The first, by Todd, looks at psychological states and their impacts on the immune systems of those with HIV. The second, by Paul Martin, provides a series of reflections upon psychological practice with transgender clients, with an emphasis upon how social expectations and prejudices impact upon the lives of transgender people.

As a whole, then, this issue of the *Review* provides a broad picture of LGBT mental health. Not only does it outline some of the negative social contexts that impact upon LGBT people, but it also explores ways of challenging these contexts. Whilst many of the papers document poor mental health outcomes amongst LGBT communities, these outcomes are always closely connected to the factors that lead to them. Importantly, many of the papers also celebrate the resistances that LGBT people make to negative social contexts, and the supportive social networks we form to challenge social prejudices. We look forward to the ongoing publication of research that continues this work of both acknowledging mental health issues in LGBT communities and the causes of this, and which also celebrates positive mental health outcomes for LGBT people.

### Author Note

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## **FINDING A LARGE AND THRIVING LESBIAN AND BISEXUAL COMMUNITY: THE COSTS AND BENEFITS OF CARING**

ESTHER ROTHBLUM

### **Abstract**

*There has been little research on the complex phenomenon of 'lesbian communities' and even less on how bisexual women construct communities in the perceived absence of bisexual organisations or events in most U.S. cities. Sixty women (31 lesbians, 17 bisexual women, 2 women who identified as gender queer, and 10 heterosexual sisters) were interviewed about their communities. They were asked how they perceived their communities to be there for them during times of stress, and also on the converse of that — how much support they are expected to provide when others in their communities experience stress. Over half of lesbians and bisexual women were highly integrated into a number of communities and felt significant support when times were bad. Others relied on partners and family of origin when their communities were not supportive. Some women used the internet for support, whilst others felt quite isolated from any community. High involvement with communities came at a cost, however, since women had to decide how much time and effort to put into providing support for others in their communities. In contrast, the heterosexual sisters were generally less integrated into communities outside their own families.*

Keywords: lesbian and bisexual women, community, support, carework

### **Introduction**

The cover image of Alison Bechdel's comic-strip book *Strip-Level Dykes to Watch Out For* (1998) shows a multi-generational and multi-

ethnic group of friends helping to unload a U-Haul moving van. It is moving day for Clarice and Toni, an inter-racial couple with a son who are relocating to the white suburbs. Meanwhile the communal lesbian household occupied by Lois, Sparrow, and Ginger is up for sale, and those characters too are moving on. Later on in the comic strip Ginger becomes involved with a man and Lois becomes a gender-blending FTM.

For many of my friends, nothing could be further from their experience of community than this scenario. They feel isolated and lonely. They view their local lesbian community as cliquish, elitist, racist, or ageist. They say it is unfriendly to children, especially boys. When they have moved, or hurt their back, or needed a ride, no one was there for them. Bisexual women are even more disappointed. Many feel there is no bisexual community, and they must choose between being in the closet or passing as lesbian.

### **Research on Community and Lesbian/Bisexual Community**

There is a voluminous body of literature on community, and the role of community and mental health in the general U.S. population (c.f., Brugha, 1995; Hobfall, 1986; Vaux, 1988). Yet there has been relatively little research on the complex phenomenon of 'lesbian communities' and even less on how bisexual women construct communities in the perceived absence of bisexual organisations or events in most U.S. cities.

My prior research on U.S. lesbian, gay male, bisexual (LGBs) and heterosexual siblings has



indicated that heterosexuals live closer to their parents, have more contact with their parents, and perceive more social support from their families of origin (Rothblum, Balsam & Mickey, 2004). Lesbians and bisexual women are less religious, more likely to live alone, and more geographically mobile. Women who do not identify as heterosexual may become alienated from standard sources of community (such as extended family and religious organizations). For these reasons, it would seem that connection with and participation in lesbian and bisexual women's communities would be important for social support and as a buffer for stress and distress.

There has been recent interest in and research about LGB communities. Bailey, Gurevich and Mathieson (2000) reviewed the role of the lesbian and bisexual women's communities in providing support and buffering stress. Meyer (2003) has described the concept of 'minority stress' for LGB populations—the concept that anti-gay prejudice and discrimination create a stressful environment for LGBs in mainstream society. And Edwards and Riggs (2008) recently edited an entire issue of the journal *Health Sociology Review* on the ways LGB people create community and family.

### **Research on Social Support and the 'Cost of Caring'**

There has been a vast amount of research on the role of social support in reducing stress. As early as 1976, Cobb defined social support as the interchange of information leading a person to believe that she or he is valued, loved and cared for, or part of a network having reciprocal obligations. For the purposes of examining the role of communities as sources of social support for lesbian and bisexual women, I will focus on four issues from the literature, with reference to how they pertain to the present study.

First, social support is complex and hard to define. As such, many researchers have focused on the quantity of social support (e.g., numbers of friends, membership in organiza-

tions) rather than the quality (e.g., perceived satisfaction from friendships or degree of help from organisations). Edwards and Cheers (2007) have reviewed the concept of 'social capital', the connections people have within social networks. Close and dense ties provide emotional support, but very close bonds may have the cost of demanding conformity from network members and excluding people who don't conform to these norms. There are many ways that communities can provide support during times of stress, and I was interested to see how lesbians and bisexual women had benefited (or not) from their communities.

Second, there are different domains of social support. Our social relationships can provide us with tangible support (e.g., money, use of a car, childcare), they can provide love and affection, or they can give advice or feedback, among other benefits (see Solomon & Rothblum, 1986, for a review). Some people may obtain all kinds of support from one person (such as a spouse or partner) whereas others may look to different people for different things. Furthermore, the friend who provides affection will not be necessarily be useful if one's car breaks down; for that one needs a friend with a car, affectionate or not. I was interested to see which types of support women had or wanted to receive from their communities during times of hardship.

Third, the Buffering Hypothesis (e.g., Cohen & Wills, 1985) theorises that people most need social support if they experience high stress, whereas people who do not undergo stress do not benefit psychologically from social support. The proverb "a friend in need is a friend indeed" best sums up this hypothesis, which implies that social supports "buffer" people from mental health problems during times of stress. In the present study, I was interested to see whether community support mattered to women who hadn't actually experienced much stress.

Finally, the early literature on stress and social support assumed that the more friends and

supports one had, the better. Research indicated that for women, more friends meant more work when these friends became ill or needed a sympathetic ear (Belle, 1982). Thus women's social supports may themselves become sources of stress. Deborah Belle (1982) termed this 'the cost of caring'. Edwards and Cheers (2007) assessed social capital among same-sex attracted women living in rural communities in South Australia. They found women's networks to provide support, but also to place excessive demands on them. Women with lower social capital felt excluded. In order to examine the phenomenon of the cost of caring, I asked participants about ways that being part of their communities created stress for them in terms of having to take care of others.

### **The Lesbian, Bisexual and Heterosexual Community Project**

I received a grant from the Lesbian Health Fund of the Gay and Lesbian Medical Association to conduct interviews with lesbians, bisexual women and their heterosexual sisters about their communities. The announcement about the project stated:

We hear a lot about the role that 'communities' play in health and well-being, but in fact little is known about social networks and needs of adults. I am looking to interview women about the role of community in their lives. I will focus on women in specific age groups (20s, 30s, 40s, 50s, and over 50), in rural and urban settings, and from diverse ethnic and racial groups. My research in the past has compared lesbians and bisexual women with their heterosexual sisters. This is because sisters are often similar in race, ethnicity, age, religion, etc. The goal of this project is to understand what lesbians, bisexual and heterosexual women mean by 'community,' their satisfaction with their communities, and implications for stress and mental health. You do not need to have a sister to participate in this project. However, if you do have a heterosexual sister who would like to be interviewed as well, it is important that your sister knows that you are lesbian or bisexual

(in other words, you cannot be closeted if you want your sister to be interviewed as well).

I was able to pay participants, and when the announcement appeared on internet listservs I received more than twice as many requests for participation than funds allowed. Of the 60 interviews I conducted, nearly all were over the telephone, and I made the decision to limit interviews to women living in the U.S. One-third (20 participants) were women of color (African American, Asian American, Latina, Middle Eastern, Native American, and biracial) and ages ranged from 18 to 75. Not all lesbian and bisexual participants had sisters, and others were not close to their sisters; in two cases I interviewed sisters who were themselves lesbian. Of the 60 women in the total sample, 31 participants identified as lesbian or gay, 17 as bisexual, 2 as gender queer, and 10 as heterosexual.

The participants represented an extremely diverse set of communities, including the pagan, college student, retirement, dance, poly-amorous, elite athletic, butch/femme, dog lovers, music, and S/M communities. A few women had serious health or mental health problems, which impeded their ability to work. Some women were living or had lived in feminist, hippie, or Buddhist communal houses. Some worked for LGBT centers or organisations; others were extremely closeted or just beginning to come out. A few were immigrants from other countries or had lived abroad. Some had been raised in fundamentalist religious families; others were currently part of religious communities. Some women had no community; some were living in extremely rural settings far from other people. Some had few contacts outside of their partner, children and/or family of origin; others relied on the internet for their social supports. Some bisexual women were currently involved with men and others with women.

All interviews were taped and transcribed, and all names cited below are pseudonyms. Tapes were sent back to participants for them to

keep, and transcribed interviews were emailed to participants for their comments. The present article will focus only on how participants perceived their communities to be there for them during times of stress and hardship, and also on the converse of that—how much support they are expected to provide when people in their communities experience hard times.

### Analysis

#### *Community support during times of stress and hardship*

A number of participants gave examples of ways in which their communities had been there for them when times were bad. Of the total sample of 60 participants, 33 women (55%) experienced their communities as supportive during stressful times. This included 19 of the 31 lesbian participants (61%), 11 of the 17 bisexual women (65%), none of the 2 genderqueer women, and 3 out of 10 heterosexual women (30%). The examples below all refer to lesbian and bisexual women; I will describe experiences of heterosexual women in a separate section.

Perhaps the best examples of considerable support came from women who lived in intentional communities. Ciska is in her sixties and lives in a lesbian communal household. Her housemates support each other during times of stress. She stated: "My housemates are very supportive of each other with health problems or relationship problems; we treat each other like family. We visit each other in the hospitals, we coordinate people, you know, to visit, make visits to the hospital. When I was laid up for all those months, for five months I had lunch and dinner brought to me. There were not only lesbians bringing the food but also non-lesbians coming to the house". Similarly, Veronica had moved to a new city and was down to her last dollar when a Buddhist communal household asked her to move in and paid her to do various tasks around the house.

We do not typically think of colleges as intentional communities, yet colleges spend a lot of money and resources to make sure that students experience community, including mini-communities for international students, students of color, LGBT students, and so forth. Jordan is an African American lesbian in graduate school at a predominantly white university. She told me:

I would say I've been through a lot of stress and hardship here. Where I've had family members pass away or just trying to get my master's thesis together. And I think that's when at times a community definitely rallies around you to help support you in any way that they can. Whether that's getting your mind off it and taking you out to dinner; or just coming to your house to chill out; or reading over your papers or whatever, I think that the community I have I am very, very thankful for. They send you cards and flowers and things to let you know that they're thinking of you no matter what.

We definitely have a lot of parties for people. We celebrate a lot. We celebrate the last day of class. We celebrate the first week of class. We celebrate anything we can just to have that fun and laughter and joy in what we're doing. No matter how much at times we have a lot of horrible things that happen to us here, a lot of racist behavior, homophobic behavior. I've actually had a bias-related incident happen to me that had to be reported and during that time I definitely had people sending me flowers. I had directors talking to me, and all sorts of things.

Not everyone actually *lives* in community. Mary is 75 and her community consists of various organisations. She said:

I had to go into the hospital in November for a shoulder replacement, and I found that all of the women from my group were there for me. They came to visit me in the hospital, and they sent me emails asking if there was anything they could do for me. I do find support for anything that I put out. And my friend that I had breakfast with this morning, she's been very supportive in helping me around the house to do things, and yesterday she came and put a shade up for me

because I can't do it with my physical limitations right now. I don't think I seek a lot of emotional support from people. But I think if I did I would absolutely receive it because I certainly have gotten a lot of caring and wishes around my physical being from others.

There were multiple ways that participants described efforts by their communities to help them through hard times. When Elise's long-term relationship ended her friends were supportive and invited her to come live in their house. Laine identifies as polyamorous, with male and female partners. When her friend died, a number of people from her community were there for her. Jamie is HIV-positive and a single mother. She felt surrounded by support from the HIV community. Leah received support from her S/M group that meets every couple of months. The group has been very supportive about members' problems, sex, and money. She said she feels "very padded".

*For other lesbian and bisexual women, it really comes down to family and partner when times are bad*

A number of women emphasised the fact that communities were not there during bad times. Instead, they relied on their family—their partner, parents, or extended family. For example, Anna was struggling to finish college and didn't consider her lesbian community that supportive at the time. Instead, she relied on her family. Oline admitted to being an introvert, so she relied on her partner and sister for support. When Bella's community imploded, she was unwilling to share that experience with anyone other than her partner and parents. Camilla mostly talked with her mother and her heterosexual friends when her relationship ended and her parents got divorced. Cheryl is part of the polyamorous community. However, she has a chronic illness and her husband and his parents have been her main support.

Lesbian and bisexual women with children do not always find communities all that suppor-

tive. Conversely, women with children don't have much time to participate in community events. Cassie and her partner are rearing their children with another household of adults and their children. This set-up provided excellent support for childcare, but it means that none of the adults spent much time with friends or community organisations.

*The internet provides support during bad times*

Some women could not find a specific community close to where they lived, so relied on the internet when stressed. For example, Ashton has no transgender community in her town so she relied on the internet for support. She explained that the internet "feels like a conversation" and she appreciated the responses of "Oh, yeah, me too". In contrast, when she talks to people in her town, "I spend a lot of time explaining words that I'm using, because they don't know what they are".

Carmencita is very isolated in her large city; she used Facebook to make friends and call them during times of stress:

Just because of the distance and people moving on everywhere, one of the main forms I use is Facebook. It's very popular now, and my best way of keeping in touch with people and what they're doing. Sometimes my friends from (university), they're always in class, and so it's hard to find time to be together. So we usually send messages. It's a community, but it's very dispersed.

Phoenix is part of the polyamory and kink communities, and relied on LiveJournal contacts when she was stressed. She told me:

I would say through LiveJournal, that's when my friends have been there for me. I tend to log about what's going on in my life. If there's something particularly stressful going on, my friends write to me and say, don't worry about it, I know how you feel, I had to go through this.

*Community support needed to be a good fit with what women needed*

As described above, research on social support indicates that there are multiple domains of support, and there needs to be a good fit between what women needed and what the community could provide. For example, Lisa is part of the midwife and mothering community. When she gave birth herself, it was the perfect community to give her support. Robin had health problems and through the community found some really great doctors — one who was a lesbian and one who was gay.

A number of women interpreted my question about support to mean financial support. For example, Alice was working three part-time jobs and struggling financially; her community helped out by paying for things or not letting her pay. When Lynne needed money to pay her telephone bill, she mentioned this on her internet list and two people sent her the money. Rosemary's friends have learned to worry when Rosemary "cocoon" and doesn't show up for events. When she broke her leg and didn't have health insurance, the community came together and provided the money. When Susie's wallet was stolen, someone got her ATM pin number and stole her entire savings. Her friends loaned her money and gave support.

*Communities are for good times only*

As a corollary to the concept that communities have to be a good fit with women needed, some women felt that their communities were set up mainly for fun and social events. Thus they were not organised for support during stressful times. Camilla wasn't sure what the intentions are of people in her lesbian community — they might be talking with her in order to get sexually involved with her. Angelica is part of the musical and athletic lesbian communities in her city, but those social organisations are not set up to help people during times of stress. Carmencita saw the lesbian community as focused on sex and

entertainment, which meant it wasn't there when times were bad.

*There's no one to help*

For a number of reasons, some women felt isolated or unable to share bad times with their communities. This left them without many resources. Ashton, who is gender queer, saw gender as dividing her community, so that no one got much support. She has become self-reliant during times of crisis. She found help from one friend here and another friend there but there was no organised support from community.

Jean is bisexual and married to a minister. The church community perceives her as straight, so she was careful what she told parishioners. This means she couldn't make herself vulnerable. Jean is essentially 'passing' as heterosexual to most people she knows and thus experiencing support from her church community as a heterosexual woman.

Emily has a partner with chronic health problems; they live in a rural community and are very isolated. During the rare times that Emily traveled she asked a neighbor to look in on her partner, but mostly she has few supports.

The community has not supported Lavinya; she has been very isolated. She said:

Lesbians are still stigmatised as outcasts in society. As a Black woman the lesbian community is not very responsive to my needs, and that is something that I figured out a long time ago.

*But some women haven't experienced much stress*

The Buffering Hypothesis states that social supports do not provide much extra help when times are good. In fact, some women admitted that they hadn't experienced much stress. These tended to be younger women. For example, Georgina has two lesbian "aunties" whom she calls on when she is feeling

stressed. However, she admitted that she hadn't had much stress.

Wendy does not feel part of a community, but relies on her partner for support. When asked about stress, she tended to speak hypothetically. She said if things got stressful, "I could go to one of my friends....Or I could go to a therapist if we were having relationship problems". This had not happened yet, however.

### *The Cost of Caring*

Anderson (2006) refers to the notion of 'imagined communities', indicating the socially constructed nature of communities. When lesbians and bisexual women imagine the ideal community, they often picture a tightly-knit set of friends, neighbors and acquaintances who are there for them during times of stress as well as happiness. What they rarely consider is that communities that are set up to help others must by definition rope members in to providing this help. In other words, community members who are not undergoing crises should be helping out those who are. How does this work in practice?

When participants were asked in what ways they have had to help out when people in their communities were stressed, Tee's comment sums up the concept of the cost of caring:

It's draining. It's really draining. I had a hard time dealing with it at first because when I was shy it was really easy because I only had a few friends and I could focus right on them. It was really hard for me to learn that being a friend isn't just being there all the time, it's being there when they need you. It was really hard for me to learn how to be okay with just talking with them for a while and that being all right because I need to go off and do other things.

Ciska, who lives in a communal lesbian household, is aware that the care and support in the house is reciprocal. Thus, she too has taken care of a housemate who had a stroke and visited her in the hospital every day.

Rosemary is ordained in her pagan community so people come to her to get married and for funerals. This is quite time-consuming for her, although also a part of her role in that community.

Phoenix told me: "One of my friends tells me that I am just the girl who just can't say no". Male friends come to her for favors, and those favors are often sexual. She doesn't see herself as being used because they in turn also help her with food and bills.

For women who interpreted 'support' to mean giving financial support, they regretted lacking the means to do so. For example, Alice, who was receiving money from others during a time of need, wished she could give money to others.

For other women, family needs have taken precedence over community. Anna used to help out in her lesbian community when she was younger, but now her mother and sister need her help.

### *Less cost of caring because less community*

Women who are relatively isolated have an advantage when it comes to the cost of caring — they don't have to deal with demands on them by the community. For example, Angelica is new in town so people don't seek her out for support. Leah moved a bit further away from her community and now she is no longer on the "front lines" of people that her friends call on. Christine said she is lousy at caring for others, but she is close to her church and the church takes on the caretaking role. Wendy's partner is a health care provider, so she is the one who helps out with health problems among their friends.

Laine reflected on this scenario more hypothetically, thinking about it as a possible future event:

Personally, I try and, I think it should be an equal, reciprocal relationship. I know that if

my friends had called me I would've done the same for them. Friendships I guess have different levels, and what-not, but I feel like there's maybe five or six of us who I would say could do stuff like that, just be there for each other.

### *Need to set limits*

But lots of women were aware that they had to learn how to set limits to protect their time and health. As a minister's wife, Jean is expected to take care of others and visit them when they are ill. She tries hard to make her role clear so people don't make excessive demands of her. Jordan intentionally chose the LGBT office for her practicum so that she could be "more than just a face on a brochure". Nevertheless, she added, "But I definitely have to be mindful of taking care of myself too. Because there's only so much I can give, to a point where I am really bringing myself down and I need to be in good health in order to help someone else too". Lavinya tries to be less of a rescuer. She said: "I'm such a caretaker. I'm trying to heal myself from that. I'm one of those people that people come to because I'm strong".

Mary can disconnect very easily from her community to decrease stress. However, that became more difficult when she was taking care of a friend who was dying. Suzanne too said that as her community ages, more friends get sick and are dying. This means she has to make a decision about her appropriate level of involvement.

Nabaneeta told me:

I've definitely, in terms of resources, I've actually been approached previously in regards to 'hey, I'm in a bit of a jam, can you help me out?' And unfortunately sometimes it's come down to me saying, 'listen I'm still in school and I'm up to my eyeballs in debt right now. I really have absolutely nothing.' And then other times I've been able to say, well right now I can spare like maybe a hundred dollars this will get you by for a little while.' It just works out that way.

Sarah is very handy at fixing things and also has money, so lots of people came to her for help. She has actually moved out of state partly in order to alleviate the stress of helping out others.

### *What is community for heterosexual sisters?*

Before starting this project, I had predicted that heterosexual women would be primarily focused on immediate and extended family and religious institutions rather than friends and organisations. Although the sample of heterosexual sisters in this project was small (10 women) and somewhat non-traditional, this was generally the case. For example, Asmira lives with housemates, but spends a lot of time trying to get her relatives more connected with one another. She emails her extended family quite often, yet told me she wished she had more contact with her family. Chelsea has a young son, and so her community includes parents of her son's friends, as well as her husband, sister-in-law, co-workers and neighbors. She has relied on her own family during times of stress. She has recently found a church, but still feels quite new there. Zewa lives at home with her parents and brother, and has a boyfriend who lives out of state. She told me that she tends to get very stressed, so her boyfriend and sister are her main supports during those times. Church and extended family are central to Gloria. Even though she spends part of each year overseas, when back in the U.S. she spends a lot of time with her grown children, mother, and brother. Karen too mentioned her church and family as major supports. Joanne dropped out of school to have children, and her current community consists of her husbands, parents, and extended family. She felt quite isolated. Not surprisingly, when asked about ways in which they are expected to help out their communities, heterosexual women whose families were central mentioned family crises as times of greatest involvement.

Not every heterosexual sister was focused on

family. Madeleine is part of the pagan, political, and music communities, and also stays in touch with high school friends. She felt over-committed but closed off from people, and found it hard to connect. "I just don't do well talking about myself", she told me. Yet when she was stressed out, her communities have been there for her in unexpected ways. Wiley left her Mormon family of origin and created a blog to keep in touch with people. When her truck broke down, strangers on the blog sent her cash and care packages. Liz lives across the street from her yoga center, as do many of the other yoga members. This means that her community is there for her every day for advice and help.

As mentioned earlier, only three out of ten heterosexual sisters found their communities highly supportive during times of stress. Interestingly, two of these three sisters (Wiley and Liz) are connected to communities outside their families. It seems that when family is the only community, support is not always seen as adequate during bad times.

### **Conclusion: Pros and Cons of Community**

Green and Mitchell (2002) have described the social networks of lesbian and gay men as a series of concentric circles beginning with partner and moving outwards to include close friends and family members, more extended friends and family members, work acquaintances and occasional friends, and others. This last category includes organisations. They also examine factors in the social support system such as size of network, type and frequency of activities, types and quality of support, reciprocity of support, density of ties, and stability of support system over time. Green and Mitchell conclude that lesbians and gay men have LGB friends and heterosexual family networks that rarely meet, requiring lesbians and gay men to "...expend more deliberate effort to create an integrated social support system that has family-like qualities" (p. 561).

In many ways, the women I interviewed who were most integrated into communities and happiest with the support they received fit this model. They were close to a few intimate people (their partner, a sibling, a few friends) but they also viewed themselves as part of larger organisations. They identified strongly with specific communities — the dance community, the butch/femme community, etc. — and described the members, activities, and issues that constituted these communities. When stressful events happened, the community was there for them. This was particularly the case for women who lived close to — or in — intentional communities. Women who live in a communal household, for example, are expected to take care of each other when crises arise.

Dahlheimer and Feigal (1994) have described lesbian and gay communities as 'families of choice', given the failure of many families of origin to nurture lesbian and gay family members. Yet I was surprised to find that many participants mentioned their own families (partners and children) and families of origin (parents, siblings, other relatives) as major supports. It is possible that over time, lesbians and bisexual women have come out to families of origin, made peace with them, and learned how to integrate their own lives into those of their families. Or it may be that during times of stress, even women estranged from families will draw closer, especially if their other communities don't have the resources to provide support.

Certainly the internet is a relatively recent way for lesbian and bisexual women to get and stay connected. Even women in rural settings or those who felt their own town had no relevant community could stay in touch with similar others over the web. And some women even received financial support from complete strangers over the internet.

High involvement with communities could come at a cost, however. When other people needed social support and tangible assistance, women had to decide how much help to pro-



vide and how to set some limits. The 'cost of caring' is certainly part of lesbian and bisexual women's communities. There has been little focus on this concept in the mental health research, yet this is an important variable to consider when urging women to find communities for social support.

The heterosexual sisters, as a group, were not as well integrated into communities outside their families, with the exception of churches. Heterosexual sisters may have less need to form 'families of choice' given that they get help less problematically from families of origin. In contrast, lesbians and bisexual women are not automatically integrated into families of origin in the same way.

Fischer (1982, p. 12) stated: "Few ideas saturate Western thought as does the conviction that modern life has destroyed 'community.'" Yet in many ways, women's communities are thriving, and managing to provide support for their members despite limited resources. Women who manage to find communities of like-minded members at the very least find these communities there for social activities. And, during the worst of times, there is a good chance that the communities will be there to see them through.

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## **'I COULDN'T DO BOTH AT THE SAME TIME': SAME SEX ATTRACTED YOUTH AND THE NEGOTIATION OF RELIGIOUS DISCOURSE**

LYNNE HILLIER, ANNE MITCHELL AND HUNTER MULCARE

### **Abstract**

*The Christian Church<sup>1</sup> has remained relatively stalwart in its opposition to homosexuality despite other mainstream institutions such as the legal system and psychiatry recanting earlier homophobic and heterosexist positions. This rejection of homosexuality has a particularly negative impact on the lives of young same sex attracted young people during the period of 'coming out'. This paper is based on a sub-sample of 119 young people who wrote about Christianity in their lives in the second national study of the sexual and mental health of same sex attracted youth. We use Foucault's 'technologies of exclusion' and 'dividing practices' to explore how young people worked with homophobic and exclusionary religious discourse. Most eventually left the church, finding it almost impossible to incorporate their sexuality and their Christianity into one positive identity. The findings are discussed in light of young people's mental health and ways forward.*

Keywords: same-sex attracted youth, religion, exclusion, homophobia, coming out

### **Introduction**

I've heard sermons preached on how homosexuality is an 'abomination' and I've spoken to many people on the issue and done my own research too. God created me as who I am, and that includes my sexual orientation. I don't want to get caught up debating whether

or not being attracted to the same gender is a sin – all that this would lead to is spiritual defeat; I know I'm created in His image, and His grace is sufficient for me. I really value my history with the church and the beliefs associated with it, but I often feel hurt and betrayed because I feel that the church is constantly rejecting me. (Ashley, 20 years)

The experience of Christian based homophobic discourse is common to people who are same sex attracted and it can have profound effects on their mental health as well as spiritual practice. Religious discourse based on homophobic beliefs may be particularly dangerous for same sex attracted young people because it claims territory beyond the physical world and the people in it to the loss of God's love in a damned afterlife. The excerpt from a young man's letter to his parents cited above embodies many of the difficulties that same sex attracted young people experience in relation to religion and negative attitudes towards homosexuality that are based on religious beliefs. In this case, and despite being alienated from the church, Ashley was able to successfully (but not without difficulty) negotiate a path which accommodated his sexuality and his faith, though not his church. The vast majority of same sex attracted people are not able to reconcile the differences between their church and their sexuality, and as a result the majority of them leave the church (Couch & Pitts, 2006). Yip (2002) has suggested, however, that we should not assume that homosexuals who leave the church become atheists. Rather, he argues that many of this group shift spiritual authority from the church to themselves and retain a relationship with God. With this in mind, the aim of this paper is to

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<sup>1</sup> We use this term to incorporate all churches for whom Jesus Christ is the son of god.

explore the experiences of same sex attracted young people who encounter homophobic and exclusionary religious discourse. In particular, we examine how they work with and negotiate these discourses, and what impacts they have on their mental health and spiritual practice.

Despite changes over the last decades in the beliefs of institutions such as the law (Freeman, 2004), medicine and psychology (American Psychiatric Association: Diagnostic and Statistical manual of Mental Disorders, 1973), much of the Christian church in Australia has remained relatively stalwart in its promulgation of negative discourse about homosexuality and in its continued opposition to homosexuals in the church. In Australia, the struggle to hold this line in the face of medical and judicial reforms has been public, political and painful (Fraser, 2006; Herde & Shepherd 2006; Morris, 2006; Swartz, 2006) and occurs alongside a growing movement within the Church itself to move with the times and take a position which is more inclusive and accepting. There is also now a greater visibility of gay people within some churches, and more open debate about the verity of Biblical texts in providing guidance on this issue.

Homosexual Christians have taken up the challenge to remain within the church as equals. In Australia, the Rainbow Sash Movement has seen Catholics (unsuccessfully) requesting communion while attesting to their sexual orientation by the wearing of rainbow colours at mass (Kelley, 2006). The National Assembly of Uniting Church in Australia explicitly approved clergy in same sex relationships in 2003 and in 2006 confirmed this decision despite repeated opposition within their ranks (Drayton, 2003). The Anglican Church has generally held the line against ordination of homosexuals but also has more radical arms which support the view that homosexuality should be acceptable within the church (Robotham, 2006; Spong, 2003). This growing debate has allowed for a public articulation of negative discourses relating to the acceptability of homosexuality in an unprecedented way

and it is impossible to imagine that this is without impact on individuals trying to shape their lives according to Christian teaching. This experience has been elucidated by a number of high profile Australians who have publicly discussed the problems they faced when trying to consolidate their sexual difference and their Christian faith (McRae McMahan, 2004; Marr, 1999).

Yip (2002) and others (Mahaffy, 2001; Rodriguez et al, 2005) have written specifically about non heterosexual Christians and the ways they have managed the stigma that is imposed on them by the church. Yip (2002) in particular described a range of responses of this population to the church's negative stance on homosexuality. These include: denying or repressing homosexuality and continuing with the church; attempting a 'cure' through organisations which promise conversion therapies; maintaining a private gay identity and continuing to work within the local church and; rejecting the church and embracing a homosexual orientation. In Australia, it seems that the last option is probably the most common. In particular, the *Private Lives* study (Pitts, Smith, Mitchell, & Patel, 2006), one of the largest studies of gay, lesbian, bisexual, transgender and intersex people conducted across the globe, reported that non-heterosexual Australians have a very different pattern of religious affiliation to the general Australian population (Australian Bureau of Statistics, 2004). In particular, 71.5% reported no religious affiliation, compared to 16% in the 2004 census; and the proportion affiliated to Christian denominations was 17.3%, compared to 68% in the general population. Furthermore, Christian religions were regarded as less gay friendly than non Christian religions.

To understand the struggles for people to embrace both their sexuality and their faith, a post modern framework that focuses on positions provided in discourse can be useful. To this end, the present paper is concerned with same sex attracted young people, the site of struggle at the intersection of Christianity and homosexuality, and the work of Foucault in

framing this struggle. Foucault described discourses (knowledge statements or beliefs) that classify a person on the basis of difference, as dividing practices that result in alienation. Alienation happens in two ways through negative subject positions in discourse. The first divides off, or separates the subject of the discourse from those around her and the second divides the subject of the discourse from herself (Foucault, 1988). Dividing practices work through discourses that are all the more powerful when they are backed by experts and institutions with authority. In the first dividing practice, the discourse (e.g., 'Homosexuality is evil' or 'You are evil') is used by a speaker against the person positioned as different (e.g., someone who is same sex attracted), and in that moment that person is divided off from that speaker. Enough repetition can lead progressively to isolation and alienation from the whole community. In the second dividing practice, the person positioned as different takes the discourse as a 'truth' about herself (e.g., 'I am evil'). This creates an inner division with one part of the self, the Christian self, in conflict with other, the homosexual self. This inner division has been called internalised homophobia and can result in poor mental health (Williamson, 2000). Resistance on the part of the individual involves working with these discourses to construct more acceptable positions for the self.

Young people who are same sex attracted are likely to be most vulnerable at a time when they seek to make sense of their emerging sexual feelings in the context of powerful Christian discourse and an increasingly Christianised government (Maddox, 2005; Warhurst, 2006). Their positioning as 'evil' and 'hell bound' is strongly reinforced in the world around them while the more positive discourses exposing homophobia as an antithesis to their well being are harder to access. When young people, through these discourses, become divided from their families, their communities and from themselves, the impacts on their mental health and wellbeing are likely to include higher rates of self-harm, drug use, depression and suicide (Hillier et al, 2005;

Hershberger, Pilkington & D'Augelli., 1997; Howard and Nicholas, 2001; Russell, 2003).

In this paper we aim to document the ways in which same sex attracted young people in Australia negotiate the religious discourse that they encounter and the solutions they find to the dissonance between their sexuality and their faith. In particular we are interested in the impacts of these discourses on the mental health of those young people who accept the negative subject positions uncritically, and of others who creatively resist and reconstruct them. We also ask the question: Is it possible for same sex attracted young people to remain in the Christian church while at the same time embracing, and acting on, their sexual difference and if so how do they do this? In order to achieve these aims, we analyse the narratives of a subset of same sex attracted young Australians taken from a larger national survey of their sexuality, health and wellbeing.

### Methodology

The data for this paper were taken from *Writing Themselves In Again* (WTIA), the second national survey on the sexuality, health and wellbeing of 14-21 year old same sex attracted young Australians (Hillier, Turner, & Mitchell, 2005). Data were gathered through a survey which included questions about sexual identity, attraction and behaviour, homophobic abuse, drug use, self-harm, disclosure, support, feelings of safety and information sources. The project was advertised in national magazines, radio and the Internet and the survey could be filled out in hard copy or online. Ethics approval was granted by the La Trobe University Human Ethics Committee in April 2004.

There were no items specifically asking about personal religious faith in the survey, however it became apparent when examining the data that a small but significant proportion of young people mentioned Christian discourse in their responses to open ended questions, particularly in relation to wellbeing, feelings about sexuality, self-harm and in the autobiographical stories that they submitted. Given the

prevalence of religious homophobic discourse we decided to explore this emerging theme in young people's narratives. We took the view that by mentioning religion in response to probing questions about wellbeing, religion was particularly meaningful to the young people. For this paper a small number of statistical analyses were performed to explore whether this subset of participants differed from the larger sample in terms of their mental health and how they felt about their sexuality. We then analysed their narratives to find out how they negotiated religious discourses regarding homosexuality.

## Results

### *Profile of the young people*

A total of 119 out of 1747 participants (6.8% of the total national sample) mentioned religion in their qualitative responses. In many

cases they mentioned religion more than once. The average age was 18.3 years ( $SD = 1.9$ ) which was slightly older than that of the larger study ( $M = 17.9$ ,  $SD = 2.1$ ;  $t(1745) = 2.15$ ,  $p = .032$ ). Table 1 lists demographic and sexuality characteristics of these young people. Fifty-seven percent were male; around two thirds were exclusively same sex attracted and a similar proportion identified as either gay or lesbian. The majority were living in a metropolitan area and participants came from every state in Australia with the exception of the Northern Territory. Other than age there were no differences in demographics between the subgroup and the overall sample.

### ***Quantitative Analyses***

We carried out a limited number of quantitative analyses comparing the groups on their feelings about being same sex attracted, feelings about life and whether they had self-

Table 1. Sexuality and demographic characteristics

|                                 |  |                                     |   |
|---------------------------------|--|-------------------------------------|---|
| Gender                          | Male<br>Female<br>Transgender (f-m)  | 68<br>50<br>1                       | 57.1<br>42.0<br>0.8                               |
| Attraction                      | Same sex only<br>Both sexes<br>Unsure  | 80<br>31<br>8                       | 67.2<br>26.1<br>6.7                               |
| Identity                        | Gay/Lesbian<br>Bisexual<br>No label<br>Other   | 81<br>21<br>16<br>1                 | 68.1<br>17.6<br>13.4<br>0.8                       |
| Location                        | Metropolitan<br>Rural  | 105<br>11                           | 90.5<br>9.5                                       |
| State or Territory of Residence | A.C.T.<br>N.S.W.<br>Victoria<br>Queensland<br>South Australia<br>Western Australia<br>Tasmania | 4<br>30<br>30<br>26<br>3<br>22<br>2 | 3.4<br>25.6<br>25.6<br>22.2<br>2.6<br>18.8<br>1.7 |

harmed.

### *Feelings about sexuality*

Young people were asked how they felt about being same sex attracted with five potential responses 'Great' 'Pretty Good' 'Ok' 'Pretty Bad' or 'Really Bad'. The majority reported feeling 'Great' or 'Pretty Good' (Table 2). In comparison with the larger sample, however, those who mentioned religion in their qualitative responses were less likely to feel 'good' or 'great' about their sexuality and more likely to feel 'OK' or 'bad' about their sexuality ( $\chi^2(2) = 9.05, p = .011$ ).

### *Feeling About Life*

Young people were asked to rate how they felt about their life as a whole on a seven point scale ranging from Terrible (1) to Extremely Happy (7). The mean score for those who had mentioned religion was 4.7 and was significantly lower than those who had not mentioned religion (5.1,  $t(1739) = 2.75, p = .006$ ). That is, those who referred to religion in their qualitative responses felt worse about their lives than those who did not mention religious discourse.

### *Self-Harm*

Young people who mentioned religion were also much more likely to have thought of, or succeeded in harming themselves as a result

of other people's homophobia than those who did not refer to religion in their responses (52.5% and 34.7% respectively;  $\chi^2(1) = 15.28, p < .0005$ ). We give some examples of this later in the paper.

## **Qualitative Findings**

### *Dividing Practices 1: Divided off from Others*

One of the most severe impacts of homophobic abuse when it is enacted against young people is alienation from the abuser. Unfortunately, abusers can include friends, family and community. The following excerpts are examples of religious discourse that was reported by the participants as being used against them by a range of people inside and outside the church. They illustrate externally dividing practices at work. Adrian and Sally were divided off from their Christian school communities:

I go to a private Christian school and whilst I have not had to withstand any openly blatant homophobia from my teachers and administrators they have done nothing about the bashing, have lectured me repeatedly on the sins of my actions and assured me that I'm going to hell, and sit and listen as people verbally abuse me. (Adrian, 16 years)

I grew up in a small Christian school (up till year 10 ended) where they basically told us every week that that homosexuality was an

**Table 2**  
**Feelings about being Same Sex Attracted**

| Feelings about SSA   | Mentioned Religion? |      |      |      |
|----------------------|---------------------|------|------|------|
|                      | Yes                 |      | No   |      |
|                      | N                   | %    | N    | %    |
| Great/Pretty Good    | 79                  | 66.4 | 1248 | 76.7 |
| Ok                   | 29                  | 24.4 | 309  | 19.0 |
| Pretty or Really Bad | 11                  | 9.2  | 70   | 4.3  |

EVIL sin. This wasn't a very good thing to say and it didn't help me one bit'. (Sally, 17 years)

As well as suffering verbal abuse, Adrian was also physically assaulted by other students, and the lack of action on the part of the school to stop the abuse leaves us in no doubt as to his position within the school and his alienation from the school community. For Sally, knowledge statements that positioned homosexuality as evil clearly left her divided from her teachers and potentially against herself.

Christian parents sometimes alienated their children by invoking religious discourse that positioned their children negatively.

Coming from a fairly strict Catholic home it can be hard to feel great about liking other guys. Especially having your parents look down on you because of it. (Alex, 18 years)

For Alex, who felt his parents' disapproval strongly, there is evidence of a struggle to resist the second dividing practice, that is, the taking on or 'wearing' of the negative subject position which would then divide him against himself. This made it hard for him to feel good about his same sex attraction. In terms of family, there was no clearer example of an externally dividing discourse than that reportedly expressed by Chrissie's mother:

My mother threw me out of the house and said 'Don't come back till you give your heart to Jesus' (Chrissie, 16 years)

My old best friend, who was the first person I came out to, now hates me and told me that I'm going to hell etc etc. (Nikki, 15 years)

Others, such as Carolyn were alienated from a range of undifferentiated people through negative positioning in discourse:

I've been told it's a phase, that it's a sin, that I'll go to hell unless I stop this 'behaviour', that I'm doing it for attention, that I'm a man-hating dyke (Carolyn, 19 years)

Being positioned as outsiders, as evil and hell-bound was hard for these young people to resist when the 'truths' were backed by large, wealthy, respected Christian institutions. The loss of reciprocity and trust that comes with community is evidence of the first dividing practice.

### *Dividing Practices 2: Being Divided off from the Self*

The second dividing practice occurred when young people accepted the negative subject positions in discourse as truths about themselves. This 'wearing' of homophobic beliefs by the young people almost inevitably resulted in depression and self-hate. Ray and Nancy are two examples:

When i was going through the religious conviction it was very hard because i hated myself which is a lot harder than when someone else hates you. (Ray, 21 years)

Some people make you feel that life isn't worth living. Particularly Christians, amongst other religious groups that tell you that it's just a phase, or that it's wrong and you're going to hell or that you can just change. When you know deep down in your heart you didn't choose to be this way (Nancy, 17 years)

The impact often went beyond young people's feelings of hate for themselves to physically acting out this hate on their bodies in the forms of bodily mutilation and suicide attempts.

When I was younger I used to have to go to church with my family. They are Baptist and have a particularly homophobic minister. Words cannot express how much I hate this guy who made my life hell for much of my childhood and adolescence. Due to his constant bible bashing I was depressed and suicidal for much of my early teens. (Randall, 19 years)

Knowing what was facing me religion-wise and with my family i was pretty suicidal between the ages of about 16 and 19. Overdosed on painkillers once and used to cut a bit and engage in other very dangerous behaviours like driving



VERY recklessly, not so much because of people's homophobia but because of feeling totally trapped between a religion/family that didn't accept homosexuality and being who i was. (Peggy, 20 years).

The impact of the negative positioning of young people in Christian discourse should never be underestimated. It led to alienation from their communities and from themselves. For some, it led to them hating and harming themselves. Indeed the antigay sentiments from the church were the most insidious of all of the discourses promulgated against these young people, who in many cases started out as keen followers of Christ and the Bible.

#### *Resistance and new pathways*

Fortunately for the same sex attracted young people in the research, Foucault's dividing practices were not the end of the story. Yip's (2002) descriptions of the range of responses of non heterosexuals to negative church discourse were echoed by the young people in this research. Some of them denied their sexuality for a time while they embraced their faith and some accepted their sexuality and rejected the faith. In line with Yip (2002), some found their own spiritual authority not mediated by religion and a small number found churches which embraced their same sex attraction. Though some young people, at the time of the survey, continued to 'wear' negative discourse, many others found or created new discourse in which they were positioned as loved and loving individuals who were not condemned to the eternal flames of hell. In some cases, the young people developed a new discourse themselves and in other cases they learned them from other people, through reading, talking and through surfing the internet. Ingrid and Liam were typical of those who described a journey through despair to a place where they valued who they were and where they could reframe old damaging discourses.

Well, at first it felt morally wrong - I'd read a lot about how homosexuality in God's eyes was

a blatant aberration of nature, how the sodomites were punished, etc. All that crap. Then I began to research it, delve into my own feelings and analyse them along with what I found to support them and I discovered that what I had encountered was perfectly natural. And that I shouldn't feel the least remonstrance over it. (Ingrid, 16 years)

I used to feel completely terrible and suffered from a lot of self-hate regarding my sexuality (mainly because I couldn't resolve my religious upbringing with my sexuality within myself). Over the last few years, I have gradually learnt to accept myself more and over the last few months I have started to actually feel pretty good about who I am. This is thanks to talking to a lot of people, coming out, going to counselling, working to resolve my past issues with religion, and in general a philosophy to be honest and the 'real' me. (Liam, 17 years)

Young people who were able to reframe negative religious discourse, or come up with new discourses that described them in positive ways inevitably felt better about life and themselves. In most cases, however, these new and reframed discourses were outside church dogma and unacceptable to the church and Christians around them.

#### *When Christians were inclusive*

There were examples of individual Christians who were able to provide more positive subject positions for a same sex attracted young person. For example, Krista was given some support by the school chaplain and a religious friend. This was clearly a positive for Krista despite the fact that she was not herself a Christian.

The first person I talked to was our school chaplain (although I'm an atheist) and he was great. My best friends were all fantastic. Some of my more peripheral friends were a bit uneasy. One very religious friend said "I'm undoubtedly against homosexuality but I'll make an exception for you and Alison because I can see you're so smitten and very cute together". Talking to other queer people is awesome because they can relate much better. Talking to my Mum was not much fun. She said she was

supportive but was clearly VERY uncomfortable and not very understanding.  
(Krista, 19 years)

There were also one or two examples of Christians who changed their outlook over time. Elliot's brother was one:

I think i always knew i was attracted to guys, but in my younger years i didn't have a label for it, or any bad feelings about it. I know people would tease homosexuals but i never thought it was a bad thing (being gay). At age 15 my feelings very stronger and i wanted to come out. I told a lot of friends, teachers, all were supportive. Then i told my mum who was great but said i was too young to know, she told dad who said it didn't change anything. My other brother, being more religious, said it was ok but to never have sex, then he looked into having me converted. But it blew over and he's a lot older and wiser now and accepts me.  
(Elliot, 18 years)

One young man, after a very troubled journey, read about some Christians who were gay and this gave him the courage to explore the possibilities of combining both ways of being into his identity.

It wasn't until the end of the year that I began to hear of the option that there were people who were both gay \*and\* Christian out there – and as I read about this and challenged my homophobic upbringing, over the next few years I learned to better accept myself and know that this is who I am, and that it is religion that is misrepresenting god (Markus, 21 years)

There were few occasions in this study in which Christians were reported as giving support to young people. The norm in these young people's stories was rejection of their sexuality by the church and Christians in their lives. In most cases, same sex attracted young people who were Christians first tried to reject their sexuality, but in every case this had negative health outcomes, including suicide attempts, and they eventually found that they had to leave the church. Leaving the church was inevitably a painful but necessary

road to recovery – a sad loss for the church and a survival choice for the young person.

### *Individual journeys*

When, at the end of the survey, we asked young people to tell us about their experiences, many wrote about the struggle to reconcile religion and their sexual feelings. Below, we recount the stories of two young people, and their journeys out of religion and despair into self-acceptance and happiness.

Carla had an idea of her "difference" at a very early age and went on to act on her same sex attraction when quite young:

Crush on my female (and in retrospect, lesbian) teacher when i was 10. Ditto for my female teacher when i was 11, 13, 15. I always wanted to play the boy when i was playing 'families' with my friends at primary school and couldn't understand when girls started getting interested in boys since i just saw them as good to play rough sport with. ... Had my first g'f when I was 15 and that felt very right, even if we did have to sneak around and hide when we were kissing and have people whisper about us.

It was when she named her feelings as 'lesbianism' that she appreciated the difficulties this would create in the religious environment she lived in:

About 16 everything clicked, that yes i was a thru & thru lesbian and that that was gonna cause major problems due to my family and their religion.

Her response was initially to push her sexual feelings aside as was common for young people who had to reconcile themselves with religion:

Came out to everyone except my family and religious friends and then attempted to turn into a celibate, non-practicing lesbian,

The consequences of this repression of self were immediate and severe, enmeshing her in the impossible choice between family, religion

and an essential part of the self:

got lonely and more and more depressed = suicidal and self harming. Suicidal because i couldn't see how i could NOT be a lesbian and i couldn't see how i could NOT live without my family/religion so stuck between the proverbial rock and hard place death looked like a good and logical option.

Carla managed to survive this dangerous period in her life with the help of a counsellor and to get through to an age where she was more able to exercise some choices:

Got a LOT of counselling (for about 4years). At 18 met my present g'f. We went out in secret for 4 months and then it all came out in the open. Eventually got kicked out of my religion for being an unrepentant lesbian and due to being excommunicated some of my family shun me (that's the rules of the religion). Lost all my religious friends, too.

A resolution of this kind where Carla has 'chosen' her lesbianism at the expense of her religion has passed on the problem to her family who are now struggling in different ways to reconcile their loyalty to God (or their ideas about what God wants) and their loyalty to Carla, while she grieves for what she has lost:

Have had 1000s of conversations with my parents over it all - my Dad isn't happy with what's happened but he understands and we get along well. My Mum doesn't get it at all, can't get past her own grief/anger/shame, and so she doesn't talk to me. I still have a lot to do with my younger sister, one uncle, two aunties and my grandma (on my dad's sides) rest of my family i have no contact with. I've learnt to deal with/ live with that. Still makes me sad sometimes...

At 18 Carla has found a way to live in the world where happiness is possible but the cost to her remains a real one:

Pretty happy with life now. It'd be nice if things improved with my family but i'm not holding my breath.

Andrew also knew about his sexual feelings

from an early age but his first chance to identify their significance came in an environment that was not conducive to a positive awakening. Despite the fact that he did not come from a religious family, Andrew was strongly influenced by the religious ethos of his school:

I first became aware of my sexuality when i started puberty (age 10/11). The reason i went to a fundamental christian school was not due to my parents being religious, but they wanted me to have a better education and my school was relatively cheap for a private school. Homosexuality was seldom mentioned at the school however the people who ran the school were \*very\* charismatic and made a strong impression on most students, who were usually emotionally vulnerable etc at such a young age. The environment made me want to be like them and be saved by Jesus...

He now feels this interest was generated by what he refers to as 'scare tactics', which he experienced as powerful enough to make him totally reject his sexuality:

...mainly through persistent use of scare tactics, and the prospect of hell scared the shit out of me. This is what caused me to try and 'become heterosexual', as they basically said that the only way to get into heaven was to devote yourself to Jesus, being a good person and good intentions weren't enough and at that age (early high school) the last thing i wanted was to go to hell. So i believed that i could overcome my sexuality and i reasoned with myself that i was born heterosexual (as everyone was) and that i could overcome this bizarre deviation.

Totally immersed in this discourse of negativity, Andrew accepted it as 'truth' and tried harder and with great persistence to 'turn himself into a heterosexual':

So anyway at about 15 i tried to be 'one of them' and did things like pray constantly about my 'problem' and i destroyed anything 'gay' in my life, like pornography or masturbation, i actually tried to masturbate about girls instead.

The outcome of this repression for him, as for Carla, was inevitable depression and doubting of his own self efficacy:

After a number of months my depression deepened and i thought that this isn't working, as i was very committed to being straight at the time and it was very intense so i didn't think that it was due to lack of trying (although that's what the christians would have said, i didnt persist hard enough).

Until this time, Andrew accepted the negative Christian discourse as truth about homosexuality and as a result the only way for him to have a positive subject position was to be heterosexual. For him to accept and be happy with his sexual feelings he needed to question the truth of the Christian discourse

At this time (about 15? 16?) i decided to look into the validity of the religion. I firstly looked at my most feared verse (something in leviticus) which states that homosexuality is strictly wrong and those who commit a homosexual act must be put to death. I read some more of this book and found that it was very amusing ( i highly recommend it) and realised that some of the 'rules' were absolute crap. Most christians would agree but they would say that they were relevant for the times and most of the old testament is now obsolete. So to cut a long story short i thought, who the hell decided what was relevant and what wasn't, and realised it was more convenient for religious orgs to look over this fact.

Once he had been able to stand outside the negative discourse and break its hold on him he was then able to construct a critique which freed him from it altogether:

I delved deeper into the bible and ... and realised that there was nothing in it that says homosexuality is wrong -- nothing substantial. There were so many holes in the religion and bible that i realised it was ridiculous to take it seriously. And even if the christian god did condemn homosexuals i couldnt care less at that stage as that god would be a total bastard. So it was generally with these revelations that i suddenly became happy (with my sexuality) and i saw through christians and my school fellows.

Andrew then found his way into more supportive environments in which religion has become a mere 'interest in theology', integrated with the rest of his life. Friends are providing the support he is still not prepared to seek from his parents:

I also found solace in my extra curricular activities, being involved in the youth music scene, as this scene accepted diversity more than any other environment i had been in. I still didnt come out until after i had graduated as i knew that if it got back to the school, they would have undoubtedly told my parents, and i wasnt ready to do that just yet... When coming out i didnt have any problems with friends, i knew this would be okay before i came out. So presently...ive developed an interest in religion and theology (it doesnt consume me though and i do have many other more exciting interests) and in community service and gay rights.

Carla and Andrew's stories are typical of the struggle young people have in coming to terms with their homosexuality in a religious environment. Both of them suffered and questioned over a long period of time, needing to be older and more independent to be able to work to reframe the discourse before they could reach some sense of resolution. Both made the initial choice to stay with their religion and to put all their energy into denying their sexual feelings. The consequence of excising part of the self was depression, self-hatred and, in Carla's case, a desire to self-harm. Resolution and peace were achieved only through the rejection of the negative discourse and those who support it even though it meant losing their Christian community. In both these narratives young people who would willingly have remained within the church, were driven away by the intractability of the Church's position.

### **Discussion and Conclusion**

Our findings are consistent with previous research that has documented the tension between being gay, lesbian or bisexual and living in a homophobic religious culture, and the negative impact this can have on an individual

(Buchanan, Dzelme, Harris and Hecker, 2001; Mahaffy, 1996; Thumma, 1991; Yip, 2002). In particular, a same sex attracted young person must work to actively resolve the dissonance between religious beliefs and sexuality. The data indicate that until this is resolved, young people are vulnerable to a number of negative health outcomes.

Of course, overcoming religious negative discourse does not mean that young people are still not vulnerable to other forms of societal homophobia. We do not know whether successful resistance to one form of homophobic discourse improves a young person's ability to resist other forms.

The stories we have explored around the theme of reconciling homosexuality with a Christian life are stories of young people facing life-threatening struggles that tear at the very core of their being. In the main they face the worst of these struggles without any of the supports that young people generally have from family members and other supportive adults. Often help cannot be sought from families and friends because the risk to the relationship is too great. Help sought from spiritual advisors is often the catalyst that pushes them to the most dangerous parts of their personal journey. Their stories are ones of great courage and initiative, both of which are employed to bring them to a better safer place. Families, friends and Christian churches who lose out in these struggles are without doubt the poorer for it.

The quantitative analyses indicated that the young people in this study who mentioned religion felt worse about being same sex attracted than those in the larger sample who did not mention religion. They also felt worse about their lives on the whole and were more likely to have thought about or succeeded in self-harm than the rest of the sample. While there is an arbitrariness about these groupings (ie. whether or not they had mentioned religion in their qualitative responses), the findings are consistent with the qualitative data and we therefore believe that they are fairly ro-

bust. We argued in the introduction that young people who had been most affected by homophobic religious discourse would be more likely to mention it when discussing their wellbeing, the data on the participant's feelings about their sexuality and reasons for self harm seem to support this.

The participants in WTIA were not directly asked about their experience with religion and so it is not possible to say how these experiences generalise to the broader population of same sex attracted young people in Australia. It would be expected, however, on the basis of past research and the widespread use of Christian based homophobia in our community and by political leaders that the experiences documented in this study are common to many same sex attracted young people. Given that Christian discourse was salient to these young people, they provided a useful group for an in-depth examination of how same sex attracted young people experience and negotiate homophobic religious discourse and its impacts. Future lines of inquiry would want to examine how representative these experiences are and look more closely at the religious and spiritual aspects. In particular, we did not take into account the religious affiliation of the participants and how this may influence their experiences. The influence of religion on sexual attitudes and behaviour varies across the different types of religious affiliation (Cochran and Beeghley, 1991) and so it would be expected that young people's experience would vary across different types of Christian and non Christian religions. Furthermore, research on the types of religions these young people are drawn to when they move away from Christianity (eg. Wicca and alternate spiritualities) which are more inclusive of sexual diversity would help us understand the ways same sex attracted youth are able to work with religious discourse when spirituality remains an important aspect of their lives. Further research with same sex attracted young people who belong to Christian churches who embrace their sexuality such as the Uniting or Metropolitan Church would improve our understanding of the ways that

Christian discourse can be reframed and used in a positive way.

In working for positive acceptance and support of these young people within schools, we have found that the moral issues of individual conscience can be side-stepped, even in religious schools, in favour of action around duty of care and safety. In some cases this may also extend to equity and human rights (Hillier & Mitchell, 2004). Within the Christian church, however, such an approach is rarely possible as doctrine suggests that the issues are essentially moral and must be hammered out in the territory of Biblical truth, Christian theology and a sense of individual conscience and worth.

It is essential that the Christian church and other institutions such as schools and youth groups based on a religious ethos are challenged in their total rejection of same sex attracted youth in their care. It remains surprising and a real concern that the church appears to be unable to extend God's love to these young people except on the most conditional of terms. While a "love the sinner, not the sin" approach is essentially unsatisfactory and damaging to young people in the long term, it may provide a means by which some short term safety and support can be offered to young same sex attracted Christians trying to work through the issues. We have found in our work that the paradigm of safety and well-being is a useful perspective from which to mount such a challenge, particularly within church schools where "duty of care" is part of the professional practice of all teachers (Hillier and Mitchell, 2004).

Young people struggling to reconcile religion and same sex attraction do so in an environment which often includes a religious family which in turn will have to replicate the struggle of the young person if the family is to remain in tact. It is unlikely that most families will wish their child to come to harm in this struggle although some are clearly prepared to condemn their child to eternal damnation. Secular, health related information materials

for families about same sex attraction can help to counter the impact of negative religious discourse on a family and provide a 'safe' positions for the child to remain included and supported. As mentioned in the introduction, religious discourse based on homophobic beliefs is particularly dangerous for same sex attracted young people because it claims territory beyond the physical world and the people in it to the loss of God's love in a damned afterlife. The impacts of these discourses on young people's mental health and wellbeing are profound and are contrary to fundamental teachings of the church in regard to love, compassion, inclusion and tolerance. It is a sad irony that the institutions which lay claim to a belief system that is based, above all on love, are actively engaged in creating the discourse that impacts in such negative ways on same sex attracted young people's lives.

These data clearly show how negative positioning in Christian discourses works to divide and disrupt the close relationships same sex attracted youth have, impacting on their self worth, their health and their well being. Also evident were the myriad of creative ways that same sex attracted young people were able to work with religious discourse, sometimes reframing and other times rejecting to create positions within discourse that were affirming and health promoting. This is a good news story for same sex attracted youth within the church. The positions are not fixed, they can be worked with and it is possible in some cases to 'do both at the same time'.

### **Author Note**

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## **A PUBLIC SILENCE: THE DISCURSIVE CONSTRUCTION OF HETERONORMATIVITY IN PUBLIC MENTAL HEALTH SERVICES AND THE IMPLICATIONS FOR CLIENTS**

DAVID SEMP

### **Abstract**

*How well do public mental health services (PMHS) address the needs of queer<sup>1</sup> clients? In the 30 years since homosexuality was de-pathologised by the APA, the field of lesbian and gay psychology has proliferated. One disturbing body of research suggests that men who have sex with men are at greater risk of suicide and other mental health problems. Many attribute these data to the effects of homonegative discourses and practices. Accordingly, mental health clinicians need to be able to identify when they are working with clients for whom these mental health issues are relevant. PMHS services often deal with people experiencing the most severe distress. However, within the literature on mental health issues for queer people, there is a relative dearth of information on PMHS. Within this limited research, there are many suggestions that such services should make themselves more affirmative of queer clients. Yet, how do clinicians know if their clients are queer and struggling with the effects of homonegativity? In this paper, I use interviews with queer staff of PMHS in Aotearoa/New Zealand to explore how a Foucauldian discourse analytic approach can help reveal the ways in which various discourses construct heteronormativity within PMHS and produce significant barriers to clinicians identifying queer clients. This has implications for clinical training and practice.*

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<sup>1</sup> I am using 'queer' to denote same-sex attracted people in the broadest sense and to signify that many do not identify with the common terms of lesbian, gay or bisexual. For a discussion of various limitations and strategic possibilities of 'queer' as a term, see Halperin (1995).

Keywords: public mental health services, queer clients, homonegativity, barriers to inclusion

### **Queer and Public: Locating the Research**

How well do public mental health services (PMHS) address the needs of queer clients? It is now over 30 years since homosexuality was de-pathologised by the APA. In this time, the field of lesbian and gay psychology has proliferated. One disturbing body of research suggests that men who have sex with men (MSM<sup>2</sup>) are at greater risk of suicide (Fergusson, Horwood, & Beautrais, 1999; Remafedi, 1999; Sandfort, de Graaf, Bijl, & Schnabel, 2001), mood disorders (Fergusson et al., 1999; Gilman et al., 2001; Sandfort et al., 2001), alcohol and drug problems (Anderson, 1996; King et al., 2003a) and other mental health problems. Many attribute these data to the effects of experiencing homonegative discourses and practices. Correspondingly, there are suggestions that mental health workers should support queer clients to explore their sexual orientation (King et al., 2003a; McFarlane, 1998; Platzer, 2006).

However, if staff in PMHS are to better support clients experiencing homonegative distress, they need to be able to identify such clients. The sparse literature on, or including, PMHS for queer people, suggests that many queer clients find it difficult or impossible to

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<sup>2</sup> MSM is commonly used to denote 'men who have sex with men'. It is used in much research as a behavioural description to avoid using identity labels that many MSM do not identify with such as gay or bisexual. The focus of my PhD research was on mental health services for MSM.

disclose sexual orientation and related issues within PMHS (Golding, 1997; King et al., 2003a; McFarlane, 1998; Semp, 2006). It also seems likely that clients struggling most with the effects of homonegativity are least likely to disclose freely (Platzer, 2006; Semp, 2006). Given this context, it is important to ask 'how do clinicians ascertain if their clients are queer and struggling with the effects of homonegativity?'

There is little research on the intricacies of the relationships between queer clients and staff within mental health services. For example, while research tells us that many queer clients feel ignored or uncomfortable about disclosing sexuality related issues (see Golding, 1997; McFarlane, 1998; Platzer, 2006), we know little about how staff participate in this. While assumptions are made about 'homophobic attitudes' and heteronormative practice of mental health staff, I could find no research exploring how mental health workers account for their practice regarding identifying clients who may be struggling with the effects of homonegativity. Accordingly as part of a wider project, I interviewed 12 queer staff who were working within PMHS in Aotearoa/New Zealand.<sup>4</sup> Given the problematic but oft made suggestion that lesbian and gay staff are likely to be an integral part of improving mental health services for queer clients,<sup>5</sup> I thought that exploring their ideas would be a useful starting point. Due to living with the effects of heteronormativity, it seemed possible that sexual orientation may be a more salient issue for queer staff and that they could comment on their own practice and that of their hetero-

sexual colleagues.

Here I consider two main areas of the interviews with queer staff. First, how staff talked about the potential significance of sexual orientation for mental health. Second, how the staff talked about identifying if clients had issues regarding sexual orientation. Further, in contrast to the often liberal and individualistic focus of much positivist lesbian and gay psychology (Platzer, 2006; Semp, 2006), I chose a discursive approach to the study.<sup>6</sup> I argue that the staff's talk illustrates discursive practices that help construct the invisibility of MSM clients in PMHS.

### **Discourse and Clinical Practice**

A Foucauldian discursive approach enables the investigation of how culturally available discourses inform and construct practice. The primary focus is "upon the availability of discursive resources within a culture ... and [their] implications for those who live within it" (Willig, 2001, p. 107). Discourses construct objects such as 'the homosexual' and 'mental illness' (Parker, 1997). They then construct 'truths' about these objects that become reified as normal and natural. Foucauldian discourse analysis asks "questions about the relationship between discourse[s] and how people think or feel (subjectivity), what they may do (practice) and the material conditions within which such experiences may take place" (Willig, 2001, p. 107). In other words, it has a critical focus on the relations of power between discourses, institutional practices, and the ways people are enabled and constrained by, yet also attempt to resist, discourses. This paper utilises a critical discourse analysis to reveal the ways in which various discourses produce significant restraints to identifying queer clients within PMHS.

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<sup>3</sup> For brevity, throughout the article I will generally use 'staff' to mean 'queer staff'. I will specify when I refer to heterosexual staff or all staff in general.

<sup>4</sup> I also interviewed 13 MSM clients who at the time of the interview were, or had been clients of PMHS in Auckland, Aotearoa/New Zealand. However, these interviews are not the focus of this paper.

<sup>5</sup> For a discussion of some problems with the assumption that lesbian and gay staff will necessarily improve mental health services, see Semp (2004a,

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<sup>6</sup> This use of a deconstructive methodology as a corrective to positivist approaches emblematises lesbian and gay psychology, and is characteristic of much British lesbian and gay psychology (D'Augelli, 2002; Kitzinger & Coyle, 2002).

Elsewhere I have outlined key discourses relevant to this study (Semp, 2004b, 2006). Discourses of homosexuality include, but are not limited to, the equal rights, radical liberation and pathologising discourses. Discourses of mental health include medical, psychological, and critical. As these three discourses are central to the analysis to follow, I briefly outline them here.

Foucault argued that during the 18<sup>th</sup> century emerging medical discourse invested the psy disciplines with the power to categorise, name, and have discipline over 'mental diseases'. He contended that what were described as 'diseases' were, in fact, constructed out of the moral imperatives of the time.

The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification. It would not be a dialogue. (Foucault, 1961/1988, p. 250)

The medical discourse relies upon biomedical models of mental health, where the 'illness' is located within individuals. Treatment is directed by 'objective' experts and requires compliance of patients (Banton, Clifford, Frosh, Lousada, & Rosenthal, 1985).

Like the medical discourse, the psy discourse relies on 'objective' experts to diagnose and treat disorders (Hare-Mustin & Marecek, 1997). Problems, while perhaps originating in relationships with others, are located within faulty cognitions and behaviours of diagnosed individuals (Kitzinger, 1997). However, unlike the medical discourse, the humanistic strand of the psy discourse requires the psy mental health professional to be 'client centred' (Davison & Neale, 1990) and collaborative with clients (Corsini & Wedding, 1989). The psy thus constructs clients as active participants in their own treatment.

The critical discourse focuses on politics, power, inequality, and individuals' relationships to society (Hare-Mustin & Marecek, 1997; Prilleltensky & Fox, 1997; Svensson,

1995). Mental health problems are located in the relationship between social contexts and individual lives (Drewery, Winslade, & Monk, 2000). Mental health practice thus becomes a political act, with a responsibility to challenge inequality (Hare-Mustin & Marecek, 1997; Nightingale & Neilands, 1997). Within this framework mental health professional can use their own experience for liberatory goals. Clients are constructed as active collaborators in finding solutions to problems (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995).

### **To Ask or Not to Ask? That is the Question**

The remainder of this paper uses data from the interviews to illustrate multiple discursive practices which operate to reduce the chance that staff in PMHS (queer or heterosexual) will ask clients about sexual orientation. These practices can be categorised as those that prioritise a biomedical focus in PMHS; those that largely construct staff in PMHS as active in directing treatment (and construct MSM clients as relatively passive); and those that rely on more active subject positions for MSM clients and their families. In particular, I argue that in different ways, both the medical and psy discourses fail to adequately account for the impact of homonegativity on queer clients, and on the provision of mental health services.

#### *Prioritising Bodies and Symptoms*

Within the medical discourse and for much of the 20<sup>th</sup> century homosexuality was pathologised by the psy disciplines. However, since 1973, this has not been the case in the DSM. Yet, while the DSM no longer directly links homosexuality and mental health problems, most of the MSM clients interviewed theorised links between the effects of homonegativity and their mental health problems. Accordingly, I explored the ways the staff conceptualised the relationships between homonegativity, mental health and PMHS. I suggest that the ways in which these relationships are concep-

tualised are likely to impact on how important staff think it is to discuss sexual orientation within PMHS.

Consistent with psy and critical discourses on mental health, at times during the interviews most staff talked in ways acknowledging the role of homonegativity in understanding mental health problems for MSM:

Patrick: Those that work in a family therapy basis often are better at it [working with MSM] because some of the factors that lead to self harm can be about sexuality and a struggle with it can be about parental reactions to their sexuality, can be about that they are getting in to high levels of alcohol and drugs as a reaction to shame and guilt and all sorts of things really.

Simon: I think that you can't work with queer people ... effectively and safely without an appreciation of the wider sociocultural context that the people live in and grow up in and I think that is one of the main areas where psychiatry went so very wrong when it came to queer people because it got sort of really hooked on looking for an intra-psychoic cause for homosexuality and a very pathologising one and it couldn't, in any way, appreciate the impact of homophobia and the wider culture.

Patrick deploys psy understandings of intra-psychoic and familial conflict as causing distressing emotions in order to conceptualise the mental health problems of MSM. Simon adopts a more critical discourse by acknowledging the sociocultural context, and the impact of heteronormativity, in the construction of mental health problems. These enable him to critique the individualising medical discourse which advocates the search for individual causes of homosexuality. Such psy, and critical, conceptualisations of mental health potentially open a space for giving greater prominence to discussions about the possible relationships between homonegativity and mental health.

However, sometimes the staff also spoke in ways that prioritised the medical discourse with its focus on diagnosing and treating

'disorders':

Diana: I mean same as anybody else, we are all going to get it [schizophrenia] one day or other, or not, you know, if we are in that group. You know, genetic disposition to schizophrenia, it doesn't matter if you are gay or not gay, you can still get it. It is just the same as whether you are black or white or rich or poor.

Matt: Well I think first, and foremost, the service is designed for people with mental health issues and I suppose Axis I, and Axis II, diagnosis. The sexual orientation would fit in probably on sort of as a secondary.

Diana describes disorders within a bio-genetic medical discourse in stating that regardless of sociocultural variables, anyone "can still get it". Matt also speaks of the medical discourse in specifying the primary role of mental health services as dealing with disorders as defined by DSM. Their role as clinicians, as constructed by the medical discourse, makes talking about sexual orientation "secondary" to talking about mental illness and diagnosis. This move reduces the chance that staff may see such conversations as important or relevant to their work. From this perspective sexuality is an epiphenomena that gets subsumed by a medicalised, disease based view.

While the medical discourse assumes bio-medical aetiology of mental health disorders, the psy discourse does acknowledge the role of prior experience and learning in familial and social contexts. However, the construction of psychiatric diagnoses further marginalises the effects of homonegativity on mental health. The diagnostic system most commonly used in New Zealand PMHS is the DSM. In this classification system the symptoms needed to diagnose 'mental disorder' are categorised on Axis I or II. These diagnoses are often pivotal in guiding treatment. Within this framework, the homonegative contexts theorised by the MSM clients as central to their mental health problems would go on Axis IV. However Axis IV is for "Psychosocial and Environmental Problems" (American Psychiatric Association, 1994, p. 29) and is not, in itself, considered diagnos-

tic of a 'mental disorder'. Thus, as reflected in Matt's comment above, the effects of homonegativity are marginalised in relation to 'mental disorders'.

From a critical discourse of mental health, this hierarchical ordering of information in DSM reveals how the medical and psy discourses, with their emphasis on symptoms of disorder, are given greater discursive power to define problems and, thus, to define the focus of clinical attention.<sup>7</sup> The DSM also reinforces the medical and psy discourses by conferring the right to name 'disorders' on mental health clinicians rather than on the people experiencing mental health problems (Madigan, 1999; Raskin & Lewandowski, 2000). Through these processes 'disorders' are generally understood in ways that minimise or deny sociopolitical context (Brown, 2000; Duffy, Gillig, Tureen, & Ybarra, 2002; Fee, 2000; Ussher, 2000). Accordingly, many have argued that despite its claims to be atheoretical, the DSM is a discursive practice that constitutes rather than simply describes disorders (Crowe, 2000; Gergen & McNamee, 2000; Parker et al., 1995).

Therefore, through the DSM, the medical discourse and to a lesser extent the psy discourse provide arguments contrary to a critical discourse which constructs more contextual and sociocultural forms of mental health service provision; ones that might prioritise a focus on homonegativity. This discursive tension is produced by multiple, and contradictory, discourses, and may explain the complex positions some staff occupied during the interviews. For example, Edward draws on multiple discourses when discussing mental health problems of MSM:

Edward: It [homosexuality] may well be an issue that they [a client] would like to have dealt with but it is not the core of, not sort of that organic thing. I know that when you refer to organic you are usually talking about actual

physical damage but I mean if you look at the schizophrenia and bi-polar disorders, which can be medically treated as opposed to therapised, I don't think sexuality - this is personal here, however, there are bound to be studies out on it - but I don't think sexuality actually is critical to bring them to wellness. I don't think that a schizophrenic person becomes psychotic because they are gay but certainly being gay may well be a stress that could contribute to an onset of psychosis. How's that? So it is something that, perhaps, they would want dealing with but it is not core to the reason that they are here. Whereas somebody who is deeply depressed because they can't adjust to their sexuality, that is and that would - so then it becomes very apparent very quickly that this is what this person needs to deal with.

Edward provides an account drawing on both medical and psy explanations. He separates mental illnesses, in a bio-medical sense, from situations where profound distress could result from intra-psyche conflict about their sexuality. However, Edward is less clear about the possible connections between mental illness and stress due to homonegativity. He uses the biopsychosocial model to try and account for this by categorising 'gayness' as a stress that can trigger a genetic predisposition to schizophrenia, thus privileging medical explanations over psy and critical ones.<sup>8</sup> The 'stress' of being gay can trigger a pre-existing disposition to psychosis but it cannot cause it by itself. By deploying a medical discourse, Edward constructs mental illness in the biological sense as being the 'core' of the work staff need to do in PMHS.

Yet, while talking in ways that maintain the authority of medical conceptualisations of mental health and PMHS, Edward also feels constrained by the medical discourse:

Edward: Yeah, but there is also the barb that I'm essentially working in a ... medical model, and I'm trying, and in many respects as a social worker I try and actually buck the system and get away from the medical model. Because

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<sup>7</sup> Elsewhere I contend that while the DSM is a product of the discipline of psychiatry, it utilises medical and psy discourses in its construction (Semp, 2006).

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<sup>8</sup> For critiques of the biopsychosocial model see Read (2004) and Semp (2006).

if I followed the medical model all I'd be, would be a glorified nurse that knows how to go to WINZ.<sup>9</sup>

DS: And reminding people to take their medication.

Edward: Precisely. So I, and that 'clinical' - the use of the word 'clinical', and it is all about language, of course, but the use of the word 'clinical' implies a medical model, and in many ways I don't work within a medical model. I work within a social justice model and I think that's where perhaps that blurring of the clinical versus personal comes into it.

Edward complains that the medical construction of PMHS limits his role as a social worker. In order to assist his clients, and to not become a pseudo-medical clinician, he describes resisting the medical discourse by trying to "buck the system" and following a "social justice model". Here Edward uses language from his social work training that is constructed more within a critical discourse of mental health. Further, to distinguish himself from his nursing colleagues Edward challenges the objective clinician subject of the medical discourse and instead advocates a more critical and political approach to mental health which he describes as a subjective "personal" one.

The example from Edward illustrates that staff can have competing, and contradictory, loyalties. They may be loyal to both psy and critical discourses of mental health, which construct the effects of homonegativity as potentially central to mental health. However, they may also be constrained by the medical discourse which operates to minimise the place of sexual orientation in the proper business of PMHS. Most of the staff spoke in ways that acknowledged this discursive complexity.

Queer staff's divided loyalties also raise an-

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<sup>9</sup> WINZ is the abbreviation for Work and Income New Zealand, which is the primary government department in New Zealand for administering unemployment, sickness and other social welfare payments.

other question. From an equal rights discourse of homosexuality, and from psy and critical discourses of mental health, queer staff are assumed to have a greater ability and interest in supporting queer clients within mental health services due to their sense of belonging to a minority group with a shared identity. Thus, their dual locations as queer on the 'inside' of their identities, and queer inside PMHS are assumed to help them support queer clients. But if queer staff do not necessarily consider sexual orientation as 'core business' within the practice of PMHS, then what does this suggest about how important non-queer staff may consider it to be, if they even consider it at all? To begin to address these questions I now explore how queer staff talked about the ways in which they, and their colleagues, ascertain if homonegativity is relevant to clients' mental health issues, or whether homonegativity is even considered.

Sometimes staff in PMHS already know about the sexual orientation of clients from information sent by referrers such as doctors.

Ella: Or if there was a GP referral. Often a GP would say, 35 year old gay male, that kind of thing. So if the referral makes reference to it. But the system that I work with wouldn't necessarily elicit that information of itself.

Yet this was something that few staff mentioned. Instead they tended, like Ella, to say that they, (and their colleagues), did not usually ask clients about sexual orientation. However, the reasons they gave for this varied.

### *'Knowing' Clinicians and 'Fragile' Patients*

Within medical and psy discourses, the subject positions of mental health professionals require that clinicians use their 'clinical judgment' to guide clinical interactions. This is clearly one of the ways in which queer staff spoke about deciding whether or not to initiate conversations about homosexuality with clients:

Ella: I think when I say that it [sexual orientation] wouldn't be asked, I don't think it would be asked in the initial interview but, certainly, once you had a key worker or a therapist I think that it would be – it would never probably be explicitly asked but it would become obvious.

Edward: They probably wouldn't be necessarily asked - I mean you don't ask every person if they are gay but there are enough, there is enough information gathered that one would ask that if it was apparent that relationships were an issue, and then that would bring you into sexuality questions and then it would become either black or white I mean even if the person lies you more often can tell.

A medical discourse positions users of PMHS as passive recipients of 'knowing' practitioners. From this discourse, clinicians assess what is important in treatment. Ella says that sexuality would be apparent without explicitly asking, and Edward says that it would become clear to staff if sexual orientation was relevant, even if a client actively denies it. Both staff talk about mental health professionals as the 'knowing' clinicians of the medical and to a lesser extent, the psy discourse. From this position they can determine if a client is queer and/or if sexual orientation is an issue for a client. One might wonder what signs enable them to make this assessment. An example of this is given by Luke:

Luke They'll say, "I think he might be gay because he's got long fingernails". That was an example that they gave to me and I just sort of said "oh right, is that the only reason you think this guy might be gay?" and then they were going, "oh well I don't mean it like that".

Luke describes some of his colleagues using heteronormative assumptions about the 'femininity' of MSM to guide their assessment. Through the lens of heteronormative masculinity men with recognizable 'feminine' features are constructed as potentially homosexual.

However, even when 'knowing' clinicians thought that homosexuality might be relevant for a client, they often had reasons for being

very cautious about discussing it with clients. Concern over possible harm to clients was often cited by staff as a reason to be reticent in starting conversations about homosexuality:

Diana I mean our job is to suss out how people are. I mean if we can suss out that it would be probably okay for this person to, for us to say look, "have you thought about your sexuality?" Being quite open about it in a careful way. If we can tell that this person would totally freak then [we would not ask about sexual orientation].

Philip First of all I ask about the young person's friends and what they do, and who their friends are, and get names of them, and then I ask about what they do with their friends, what they do to hang out, what they do to get their kicks and stuff. And then I just ask if any of the names that they gave me are particularly close friends and sometimes they say "Yes" or "No", and sometimes they say, "What do you mean?", and so I get more explicit and yes, sometimes with some young people I say "Do you have any boyfriends or girlfriends who are close friends?" And sometimes I, if I get a feeling that the young person isn't ready to hear that I sort of skirt around it a bit more and ask in a more indirect way.

Diana portrays the 'knowing professional' subject of both the medical and psy discourses by arguing that it is important for clinicians to determine if a client will panic if asked about homosexuality. Philip gives a detailed explanation of how he tries to open up space to discuss homosexuality, yet ends by saying that if he discerns that the young person is unprepared to discuss sexuality then he uses indirect approaches. These excerpts illustrate how staff often do not ask patients about their sexual orientation. They also suggest that even when staff do try and raise the topic, they may do so in ambiguous ways. Combined, these practices work to maintain a silence around sexuality. How might we understand these practices?

One possibility is that the references to clients 'freaking out', feeling threatened, or challenged, or being unprepared, make sense in

relation to heteronormativity. Heteronormativity marks homosexuality as 'abnormal' and 'inferior' to heterosexuality. In conjunction with the responsibility of being 'knowing' mental health professionals seeking to 'do no harm', asking an already distressed person if they might be homosexual can be seen as just too risky, or as one staff member stated "I mean we can't be too blatant because they are too fragile" [Diana].

This positioning of clients as "fragile", while present in the psy discourse, is particularly accentuated in the patient subject of the medical discourse. In this discourse clients passively need care from professionals. Constructing clients as fragile renders them easily broken, vulnerable, and debilitated. This positioning works to strengthen the medical mental health professional's role of needing to protect clients from an assumed serious harm. However, much is omitted from this positioning. It fails to consider that clients may benefit in the long term from addressing their sexuality. It fails to conceptualise clients as able to tolerate distress. Also, it fails to consider how this practice supports the continuing invisibility of homosexuality within PMHS, even when it might be relevant to clients' mental health problems.

### **Clients as Active Participants**

Thus far the analysis has shown how the medical and psy discourses construct active roles and associated practices for staff in PMHS, through which issues of sexual orientation are marginalised. I now turn to discursive practices which while constructing more active roles for MSM clients and their families still reveal discursive restraints that support the invisibility of MSM clients in PMHS.

#### *No Sex Please ... We're In Public!*

Some research suggests that pathologising approaches to homosexuality may be decreasing within the mental health services (King et al., 2003a; Liddle, 1999). Yet, much research has documented homophobia, or heterosex-

ism, amongst mental health professionals (Berkman & Zinberg, 1997; Caisango, 1996; Garnets, Hancock, Cochran, & Goodchilds, 1991; Golding, 1997). Consistent with this, some queer staff envisioned restraints facing heterosexual staff initiating conversations about homosexuality with clients:

Cath: Any good initial assessment should include, give people the opportunity to say how they feel about their sexuality, just as it should include any things about previous abuse, or things like that, and then I know that that doesn't always happen, that people feel uncomfortable asking it in a way that people can answer it with dignity, or still be honest, and not necessarily still be – I know it doesn't happen but it should.

Patrick: Some [staff] won't even go there and I wouldn't name names and I wouldn't necessarily say they are homophobic but they are uncomfortable about raising that question.

Cath says that not only do heterosexual staff feel "uncomfortable" asking about sexuality but that even if they managed to do it they wouldn't know how to do it in a way that made it easier for clients to answer "with dignity". In arguing that all staff should be able to ask about sexuality she likely draws on holistic notions of what constitutes a 'good' assessment and makes reference to the way staff also need to ask about abuse. Patrick also posits that heterosexual staff could feel discomfort in discussing homosexuality without being "homophobic". One way of understanding his comment is that in a heteronormative society it can be awkward for anyone to talk about homosexuality, regardless of how queer-affirmative their own views may be.

But, it is not only difficult to discuss homosexuality within PMHS. In a society where sexuality based rights, sexual abuse, and particularly professional sexual abuse, are often in the media, talking about sexuality at all can be problematic. Research suggests a relative lack of, and yet need for, discussions about sexuality in mental health settings (Assalian,



Fraser, Tempier, & Cohen, 2000; Bhui & Puffet, 1994; Cort, Attenborough, & Watson, 2001; Maurice, 2003; Park Dorsay & Forchuk, 1994; Rosenberg, Bleiberg, Koscis, & Gross, 2003). Some queer staff spoke in ways indicative of this restraint. For example:

Luke I think that people shy away from it [sexuality] because they feel uncomfortable about it, and that is why they don't want to talk about it but I think that it is a really important area for everyone, and because it is the sort of thing that is steeped in not just gay sexuality but sexuality in general, and also I guess staff's feeling about those issues, and those sorts of taboo subjects, but also about their own personal safety and how they might perceive, you know, this client and this client's sexual needs, and will they misinterpret these sorts of things? [...] And, also, I think that they would probably be worried that perhaps the clients might misconstrue their concerns about sexuality as you know, "Does this client fancy me?" or "Will this client then misinterpret our professional relationship?"

Here Luke acknowledges a general restraint to staff discussing sexuality with clients at all. One specific concern is that in raising sexuality for discussion a client may misread the clinician's intentions and wonder if therapeutic boundaries are being overstepped. Luke thus constructs clients as active participants and 'readers' of what staff say. This highlights a social constructionist notion of the multiple readings that can be made out of any given text. Some literature suggests that discussions around sexuality are fraught for many clinicians (Gutheil & Weisstub, 1996; Hedges, Hilton, Hilton, & Caudill, 1997; Pope, Sonne, & Holroyd, 1993; Tansey, 1994). These multiple concerns about discussing sexuality in any sense are yet further restraints that work to invisibilise MSM clients in PMHS.

Similarly, Beth reflected on the effects of these restraints when working in a child and adolescent mental health setting:

Beth Yeah. And I think it is, that whole, you know, the difficulty in talking about sexuality fullstop. And, also, too, with this age group

there is an awkwardness about it developmentally anyway and I think we kind of lend ourselves to that awkwardness by not kind of having kind of a nice way of dealing with it really or bringing it up. You know, you go through your initial assessment, "Was he cuddly as a baby?", "Did he walk and talk on time?" and all that sort of stuff, and when it gets to the bit, "Who do you fancy, love?", we kind of become blubbing idiots.

Beth draws on the psy discourse which posits puberty and adolescence as significant and potentially challenging times regarding one's sexuality (Paikoff, McCormick, & Sagrestano, 2000; Sharpe, 2003), especially for queer youth (Graber & Archibald, 2001; Price, 2003). Beth argues that generally staff reproduce any unease young people may feel by their own discomfort and unpreparedness. There is also some literature suggesting that these issues may be even more complex for queer staff. For example, queer staff are more likely to unintentionally see queer clients outside of therapeutic sessions, within the relatively small queer communities (Bettinger, 2002; Shernoff, 2001). Furthermore, they may see them in overtly sexual environments within queer communities (Shernoff, 2001).

### *'They'll Tell Us If They Need To'*

I have argued that due to the complexity and fraughtness of the discourses surrounding homosexuality, and mental health practice, staff described how they, and their colleagues, do not commonly initiate conversations about homosexuality. In contrast, they often spoke in ways suggesting it might be easier for MSM clients to disclose:

Matt: I think it is only a case of maybe relying on the individual then to open up and put that to the worker, the key worker. I think it is also about how, what kind of rapport that you build with the client you are working with really. If you are an open and warm person yourself then hopefully that's going to open up that person to maybe talk more openly to you.

Edward: Because if the sexuality is clinically significant then it crops up somewhere along

the line pretty soon after you've met the person, if not during the initial assessment then shortly thereafterwards.

DS: And how do you think that normally crops up?

Edward: Because the client wants it to be known.

Matt speaks from a psy discourse when he suggests that if clinicians build a trusting therapeutic relationship then MSM clients are more likely to self-disclose and initiate conversations about homosexuality. This highlights the collaborative nature of therapeutic relationships that is assumed within a psy discourse. Similarly, Edward says that sexuality will surface if the client wishes it. Both speak in ways suggesting active subject positions for clients. But what happens if MSM clients do not feel able to take up these active subject positions and to initiate conversations about homosexuality? My interviews with MSM clients and other research on PMHS suggest that these client's needs can be silenced (Golding, 1997; King et al., 2003a; McFarlane, 1998; Semp, 2006).

### **Summary: A Continuing Silence**

The opinions of queer staff discussed here draw upon two main discursive practices for how MSM are identified within PMHS. One strategy relies on the subject position of the 'knowing clinician' of the medical, and to a lesser extent, the psy discourse. From those subject positions, staff are responsible for discerning if homosexuality is an issue for clients, and for assessing the risks of talking about it to passive and 'fragile' patients. In contrast, a second strategy is for clients to initiate disclosure. From this perspective, staff see themselves as responsible for establishing trusting relationships in which clients are offered the active subject positions of the psy and critical discourses of mental health.

I have argued that many of the ways the staff talked about clinical practices surrounding identifying MSM clients are constructed within

heteronormative discourses of homosexuality. These discourses construct staff talking about homosexuality as problematic and risky for clients, and, in some cases, for staff themselves. A further restraint to staff initiating queer conversations is the predominance of the medical discourse which constructs the 'core business' of PMHS as dealing with bio-medical mental illnesses. Within this understanding, issues regarding homosexuality become 'secondary' or, at best, 'triggers to genetic vulnerability'. Another obstacle to staff initiating conversations about homosexuality with clients is a general constraint within PMHS about discussing sexuality of any sort.

Staff also provided accounts which resisted the heteronormativity of the medical discourse, often using psy, or critical discourses. However, the predominance of the reductionist medical discourse, combined with a heteronormative context, limits how effective such resistance can be. One outcome of these discursive power relations is a relative silence by staff regarding homosexuality. Some of the staff acknowledged this and its effects:

Sarah: It gives them [clients] the message that, you know, we are not aware of differences in sexuality – there isn't an invitation to talk about those issues whether they be an issue, or not, to a person.

Beth: Well I think perhaps it gets down to the culture of the agency too, that it is not something that, even though you know better it is easy to fall back into bad ways and I think that gets supported by the fact that kind of no-one is doing it [inquiring about sexual orientation], and so you get drawn back into the bad habits because it is the bad habits actually that are what exist.

Sarah says that the silence around sexuality means that discussion of homosexuality is not fostered. Reflecting on her own practice, Beth reports that this silence becomes so automatic that it develops into part of the "culture of the agency"; so much so that she 'forgets' to initiate conversations about homosexuality even though clinically she thinks such conversations can be important. What Beth is describing is a

process whereby, through heteronormative discursive practices, silence around homosexuality is reproduced. Clinicians do not raise the topic of homosexuality because it is uncomfortable or risky; then, because other staff do not talk about it, they omit to even consider it.

Therefore, I claim that discursive power relations inside PMHS operate to limit the ways queer conversations are negotiated in PMHS. Social constructionist authors on mental health practice contend that all dialogue between clients and clinicians have the potential to construct particular accounts, and to deconstruct, or deny, others (Drewery et al., 2000; McNamee, 2000; Payne, 2000; White, 1995). Yet, from a Foucauldian discursive understanding, not all conversations are equal. Some conversations are likely to seem more 'proper'. By this I mean they are less likely to break the rules of particular discourses. Other conversations then become subjugated. Heteronormative practices, supported by a biomedical discourse of mental health operate to silence staff from initiating conversations about sexual orientation with clients. This can have the effect of silencing queer clients and preventing PMHS from supporting them in their recovery. This has implications for policy, training, and practice if PMHS are to better support queer clients struggling with the effects of homonegative experiences.

### Author Note

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## FRAMING GAY MEN'S HEALTH: AN ANALYSIS OF POLICY DOCUMENTS

JEFFERY ADAMS, VIRGINIA BRAUN & TIM McCREANOR

### Abstract

*This paper presents a critical review of health policy documents from the US and Australia, with a focus on their adequacy (or otherwise) in attending to the health needs of gay men. Specific attention is paid to 1) Who gets a say in gay men's health issues in the documents, 2) How gay men's health is framed in these documents, and 3) What the role of the medical profession (and gay men) in gay men's health and wellbeing. It was found that the documents focused on deficits in the population of gay men, with either a disease orientation, or a combination of a disease orientation and a risk factor approach. Whilst a few of the documents took account of gay men's views on health, the majority promote the idea that clinicians are those best placed to determine health needs.*

Key words: gay men's health, policy analysis, biopsychosocial models, critical psychology

Worldwide, it is well established that men's life expectancy is less than women's (Lorber, 1997; Ministry of Health, 2002b; Population Reference Bureau, 2001; Raeburn & Sidaway, 1995; Statistics New Zealand, 2002), and a wide range of international research demonstrates further morbidity and mortality differences between women and men. However, there are also overall differentials between men-as-a-group and gay-men-as-a-group, suggesting the need for a specific focus on the health issues and needs of gay men. This paper takes as its focus the area of gay men's health, and explores the framing and construction of gay men's health problems and solutions provided by policy documents and research papers.

When we examine research on behavioural factors, it is far from surprising that men's health and wellbeing is worse than women's. Men in general typically engage in far more health-damaging and far fewer health-promoting behaviours than women (Cameron & Bernardes, 1998; Harding, 1998a; Lee & Owens, 2002). Men are over-represented in suicide rates (Lee, Collins, & Burgess, 1999; R. Taylor, Morrell, Slaytor, & Ford, 1998), are more likely to be involved in risk-taking behaviour leading to accidents and unintentional injury (Courtenay, 1998; Feyer & Langley, 2000) and to partake in high-risk sexual activity (Newman & Zimmerman, 2000). Men are also much less likely to moderate their intake of alcohol (Habgood, Casswell, Pledger, & Bhatta, 2001; Holtzman, Powell-Griner, Bolen, & Rhodes, 2000) and dietary fat (Katz et al., 1998), and maintain 'healthy' body weights (Bayram, Britt, Kelly, & Valenti, 2003; Holtzman et al., 2000). Men are also more likely to die at an earlier age because of coronary heart disease (Australian Bureau of Statistics, 2000; Lee & Owens, 2002). Physical activity is one area where men participate more than women (Dubbart & Martin, 1988; Ministry of Health, 2002b).

However, the health benefits of (some) forms of physical activity aside, dominant or traditional modes of masculinity are being recognised as a key aspect affecting men's health and wellbeing (Connell, 2000; Paris, Worth, & Allen, 2002; Pease, 1999). Connell's (1995) concept of hegemonic masculinity – masculinity enacted through the discourses and practices of the dominant group, and regarded as the culturally idealised form of masculine character – is a useful way to approach and make sense of men's health and health behaviours.

These characteristics are likely to manifest themselves at individual levels – including men's reluctance to seek medical treatment, and avoidance of expression of emotion – and at social levels where men are likely to give more value to work roles than family roles. Such discourses are likely to have implications for men's health individually and collectively by supporting behaviours that compromise health (Lee & Owens, 2002).

The recognition of a role for gender and health has traditionally been equated with women and health (Sabo, 1996), and most of the discussion about gender inequalities in health has focused on women and not men (Arber, 1991; Cameron & Bernardes, 1998). Health for women has historically been neglected (Porzelius, 2000) and compromised "by androcentric research, theorising and clinical intervention" (Ussher, 2000, p.1), which has resulted in a number of health inequities for women (Ministry of Women's Affairs, 2001). Feminism's focus on health issues has ensured that women's health issues are now 'on the agenda' (Kearns, 1997; Ussher, 2000), with a number of health policies and strategies relating specifically to women's health needs being introduced (Porzelius, 2000; Ussher, 2000). In recent years this has been paralleled by increased recognition that men's health is also a gendered domain, with particular health issues for men *as men* increasingly being recognised (Harding, 1998a, 1998b; Lee & Owens, 2002; NSW Health Department, 1999; White, 2002).

One of the limitations that has been noted about a gendered approach to health for men, is that it tends to depict "men's health as a homogenous condition related solely to gender" (Pease, 1999: 29) and therefore as relatively unproblematic (Hardley, 1998). One outcome of this is that despite this 'new focus' on men's health, the consequences of heterosexuality are not necessarily accounted for (Wilton, 2000), meaning that the health issues for gay men remain largely invisible and subsumed within the broader men's health experiences. Therefore, while a gendered analysis is

useful, there is also an increased recognition that looking at men as men offers too broad a basis for understanding the subtle particularities of the health of different groups of men (e.g., gay men, Indigenous men).

### **Gay Men's Health Issues**

Over the last 20 years, the area of gay men's health has been dominated by a focus on HIV/AIDS (Saxton, Hughes, & Robinson, 2002). Since its identification in 1981 (Morin, 1988), HIV/AIDS has been an obvious (and justified) area of attention. This is especially the case in Western countries where the diagnosis rate is highest amongst men who have sex with men (Dowsett, 2003; Low-Beer et al., 2002; Saxton et al., 2002) and primarily within the inner areas of large cities where gay communities/neighbourhoods and populations have formed (Eisenstadt & Gatter, 1999; Low-Beer et al., 2002; Worth, 2003). It is only in recent times that public health and other agencies, community groups and activists have begun to recognise gay men's health issues above and beyond HIV/AIDS (Meyer, 2001; Rofes, 1998, 2003; Saxton, 2001).

A growing literature suggests a number of disparities in health indices between gay men and the male population in general. Compared to heterosexual men, gay men have been found to have higher incidences of eating disorders (Russell & Keel, 2002; Williamson, 1999; Williamson & Spence, 2001), suicide (Bagley & Tremblay, 1997, 2000; Fergusson, Horwood, & Beautrais, 1999; Nicholas & Howard, 1998; Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003), cigarette smoking (Ryan, Wortley, Easton, Pederson, & Greenwood, 2001; Stall, Greenwood, Acree, Paul, & Coates, 1999), sexually transmitted infections (Saxton et al., 2002), depression, panic attacks and psychological distress (Cochran, Sullivan, & Mays, 2003), and to have an elevated risk for anxiety, mood and substance use disorders (Gilman et al., 2001). Gay men, especially those attached to 'gay communities', are also likely to use non-prescription drugs, including alcohol and tobacco, at high



levels (Van de Ven, Rawstorne, & Treloar, 2002). Therefore, the 'epidemiological picture' of gay men's health in 'developed' countries indicates a number of areas of health disparity between gay men and the population as a whole. However, despite the growing epidemiological evidence and the changing political and social environment,<sup>1</sup> the broader public health needs of gay men have remained largely ignored throughout the 1980s and 1990s (Warwick & Aggleton, 2002). Lesbian health needs have been similarly ignored, initially emerging as a distinctive area in the 1970s with 'second wave' feminism and later in the 1990s with numerous books covering a broad range of health issues (Wilkinson, 2002).

In Aotearoa New Zealand, the response to the public health needs of gay men has been muted. Public health has tended to focus on the whole population (Durham, 1999; Ministry of Health, 2002d). Recent initiatives, however, have focused on subsections of the population – for example, health and Asian people (Asian Public Health Report Team, 2003), Pacific Islands people (Ministry of Health, 2002c) and older people (Ministry of Health, 2002a). There has been no investigation or particular policy concern with the health issues of gay men as a group.<sup>2</sup> Internationally, however, there have now been a number of public health responses to gay men's (and lesbian's) health and wellbeing issues (Dean et al., 2000; Gay and Lesbian Medical Association and LGBT health experts, 2001; Ministerial Advisory Committee on Gay and Lesbian Health, 2002a, 2002b; U.S. Department of Health and Human Services, 2000).<sup>3</sup> Written with the best of intentions (to improve the health of lesbian, gay, bisexual and transgender (LGBT) people), but often with an alarming lack of insight and sensitivity, these documents also provide a (semi) public framing of gay (as well as lesbian, bisexual, transgender) health issues. They offer an identification of problems, including causes and possible solutions, mostly without a sense of the contexts of the lives of LGBT people and sometimes apparently without consultation

with relevant communities and expertise.

These documents are taken as data for this paper, to enable us to develop an understanding of the constructions of gay men's health that are contained within such documents. Policy documents relating to health issues are interesting to examine because health policy is "the product of some complex arrangement between competing discursive formulations of the problem and the solution" (Braun & Gavey, 1999, p.1465). Some of the influences will be readily apparent, and some will be less explicit and in need of foregrounding.

### **Analysing Policy: Data and Method**

A comprehensive search conducted by the authors identified six relevant documents related to health and gay men that can broadly be classified as policy documents (2), position statements (1) and research papers (3). One of these documents (Dean et al., 2000) was excluded as it was primarily a summary of research (without policy recommendations or statements) and because similar topics were covered by a later report (Gay and Lesbian Medical Association and LGBT health experts, 2001). We did not locate any Canadian,<sup>4</sup> British or Aotearoa New Zealand policy or position statements specifically relating to gay men's health. The Canadian Medical Association (1996) endorsed research into gay and lesbian health issues, but no research outcomes could be located. A British Medical Association (2003) paper on Section 28 (of the Local Government Act 1988) was peripherally related to this topic but was not included in the analysis, as it did not directly focus on gay men's health. We also excluded the *Victorian Gay, Lesbian, Bisexual, Transgender and Intersex Health Action Plan* (Ministerial Advisory Committee on Gay and Lesbian Health, 2002b) because it was in draft form. The documents on which our analysis is based are summarised in Table 1. The documents have been produced by the American Medical Association (AMA), American Public Health Association (APHA), Gay and Lesbian Medical Association, USA (GLMA), Australian Medical Association

(AuMA), and Ministerial Advisory Committee on Gay and Lesbian Health, Victoria, Australia (MACGLH).

The AMA document summarised a number of health issues related to sexual orientation and behaviour, and recommendations to enhance health care practices were provided (Council on Scientific Affairs: American Medical Association, 1996). This report appeared to be primarily aimed at medical professionals. The APHA document addressed public health research needs in relation to gender identity and sexual orientation, and identified three strategies to encourage further research (American Public Health Association, 1998). The GLMA document was intended to supplement the *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) federal blueprint for public health by highlighting a number of health issues and made recommen-

dations to improve the health of gay men. It was written for a wide audience – including consumers, researchers and health professionals (Gay and Lesbian Medical Association and LGBT health experts, 2001). The AuMA position statement addressed sexual diversity in society. It focused both on shared health needs of gay, lesbian, bisexual, transgender, and intersex (GLBTI) populations, and on the specific health needs of each of these groups. A number of statements supporting the health care of these groups were made (Australian Medical Association, 2002). The document appears to be aimed at medical and health professionals. Finally, the MACGLH document summarised the health needs of GLBTI Victorians in five areas (physical health needs, sexual health needs, mental health needs, life stage issues, and drug and alcohol use) (Leonard, 2002). This research formed the basis of a GLBTI health action plan (Ministerial

Table 1. Gay men's health-related policy documents

| Code    | Date | Producer   | Type               | Title  | Size (pages) |
|---------|------|--|--------------------|--|--------------|
| AMA     | 1994 | American Medical Association   | Policy statement   | Health Care Needs of Gay Men and Lesbians in the United States: Report of Council on Scientific Affairs                      | 6            |
| APHA    | 1998 | American Public Health Association   | Policy statement   | The Need for Public Health Research on Gender Identity and Sexual Orientation  | 1            |
| GLMA    | 2001 | Gay and Lesbian Medical Association  | Research paper     | Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health                             | 481          |
| AuMA    | 2002 | Australian Medical Association   | Position statement | Sexual Diversity and Gender Identity   | 5            |
| MAC-GLH | 2002 | Ministerial Advisory Committee on Gay and Lesbian Health, for Department of Human Services, Government of Victoria | Research paper     | What's the Difference? Health Issues of Major Concern to Gay, Lesbian, Bisexual, Transgender and Intersex (GLBTI) Victorians | 73           |

Advisory Committee on Gay and Lesbian Health, 2002b).

Our critical thematic analysis of gay men's health documents is informed by the 'linguistic' or 'discursive' turn in social science (Gill, 2000; Harré & Gillett, 1994; May, 1996), in which social research has focused on how language (and discourse) is used to create, interpret, and make sense of everyday social worlds (Potter & Wetherell, 1987; Wetherell, Taylor, & Yates, 2001). Language and discourse are seen as central to understanding and creating social worlds, with words and their meanings (and the analysis of them) varying, dependant on the social and institutional situations in which they are used (Giddens, 2001). Discursive approaches to health research are increasingly common, and this type of approach has already proven useful in exploring other health issues (e.g., Braun & Gavey, 1999; Coyle & Morgan-Sykes, 1998; Lovering, 1995; Marchant-Haycox & Salmon, 1997; Wilkinson & Kitinger, 2000).

It is important to acknowledge that these policy (and other) documents were repeatedly drafted and worked upon to produce polished, compelling outputs. This is of course quite unlike 'talk.' Nevertheless, while it is therefore harder to 'unpack' such documents, discourse analytic techniques can be applied to existing documents (Gavey, 1989; Gough & McFadden, 2001; Wood & Kroger, 2000) and have been usefully applied to health policy statements (e.g., Braun & Gavey, 1999; Sykes, Willig, & Marks, 2004), and other highly worked documents and texts (e.g., Coyle & Morgan-Sykes, 1998; Lupton, 1994; McCreanor, 1996; Ng & McCreanor, 1999).

Although our wider research interest is on gay men's cultures and identities as represented in gay men's discourses of health and wellbeing,<sup>5</sup> we are also interested in policy issues as these provide a professional and official framing of gay men's health issues. From our intensive, repeated readings of the documents, three areas and questions of particular interest emerged. They are:

- Inputs: Who gets a say in gay men's health issues in these documents?
- Scope: How is gay men's health framed in these documents?
- Roles and responsibilities: What is the role of the medical profession (and gay men) in gay men's health and wellbeing?

The analysis around these questions forms the basis of the remainder of this paper.

### **Inputs**

The documents revealed a 'diversity in voice' as to who contributes to the 'official' framing of gay men's health issues. Two main patterns – inclusion and exclusion of gay men, organisations and communities – were found in relation to the reported preparation of the documents. This section outlines and discusses examples of these two patterns.

The GLMA document and the MACGLH explicitly recorded extensive input from gay men, organisations and communities and detailed the process of inclusion. For instance, the GLMA described the scope of its collaboration:

The Healthy People 2010 Companion Document for LGBT Health is the product of a national collaborative effort that involved nearly 200 individuals, organizations, and agencies. (Gay and Lesbian Medical Association)

This collaboration included representatives from: academic and research institutions; national LGBT and health organisations; LGBT health clinics; LGBT community centres; other community based organisations; professional associations; federal, state, regional and local government health agencies.<sup>6</sup> The MACGLH established an advisory committee, including representatives of gay health/welfare organisations, and initiated consultation with gay men through an extensive community consultation process.<sup>7</sup> These documents (GLMA, MACGLH) thus explicitly identified the voice of gay individuals, organisations and communities in the process of developing policy and research in gay men's health. For these two

documents that acknowledged gay community input, social aspects of health, both causes and solutions, were identified.

In contrast, the AMA, AuMA, and the APHA documents contained no specific acknowledgment of any input from gay men, organisations or communities. A lack of (acknowledged) gay input works to frame gay men's health in a 'top-down' fashion; as a medical and professional issue. This makes the explanation and exploration of the health needs of gay men potentially more vulnerable to 'professionalisation' and 'medical capture', as doctors and other health care providers are given the authority, resources and opportunity to define the 'problems' and issues, and provide the 'solutions.' The rationale for appearing to exclude input from gay men was not commented on – and reflects the status of these documents as 'objective' scientific policy/position statements from professional medical and health organisations. Such constructions are patronising and potentially disempowering of gay men, leaving expert knowledge and responsibility for health at personal and community levels outside of their control.

The apparent exclusion of gay input into developing the documents does not necessarily mean medical, individualised framing of gay men's health issues will result, and it is to this framing of gay men's health that we now turn.

### Scope

Two alternative constructions of health – which we will refer to as biomedical and biopsychosocial – were drawn upon within the documents. The AMA document employed a biomedical framing:

Generally, men and women who engage in a same-sex behavior have the same afflictions as individuals who engage in opposite-sex behavior. Some diseases, however, are of particular concern to men and women who engage in same-sex behavior and therefore are important in a differential diagnosis and

treatment plan. (American Medical Association)

In the AMA extract, the biomedical framing was reflected by the use of clinical terms like 'afflictions', 'disease', 'diagnosis', and 'treatment.' Biomedical approaches are reductionist, focused on illness and disease (Aggleton, 1990; Morgan, Spicer, & Reid, 2002). This 'positivist' model is based on 'objective' science (especially molecular and genetic sciences), which looks within individuals for the causes of disease (Beaglehole, 2002). Health is viewed narrowly in this extract, relating to negative constructs such as illness and disease, and not to positive constructs such as healthiness and wellbeing. Despite critiques, biomedical approaches are arguably still dominant in healthcare (Beaglehole, 2002), at least in some areas and aspects. Antonovsky (1996) labelled this the 'pathogenic' orientation – focusing as it does on disease and individuals.

A broader framing of health was apparent in the MACGLH and GLMA documents:

The social environment is the major determinant of an individual's psychological constitution. (Gay and Lesbian Medical Association)

Absent from this list of social determinants of health are sexual orientation (or sexuality) and gender identity. (Ministerial Advisory Committee on Gay and Lesbian Health)

The MACGLH and GLMA documents emphasised social factors, as well as biological and genetic causes of health and illness. Key social determinants identified included socioeconomic status, race, ethnicity, gender and geographic location. The MACGLH document added a further social determinant – 'sexual orientation and gender.' This framing of health incorporated a broader social-cultural approach, acknowledging interplay between biology, psychology and society factors in relation to health (Engel, 1977). In this biopsychosocial approach there were a range of causes of disease and a range of influences on health (Hamlin, 2002). Within the last 30 years there

has been a move to this more holistic model (Porzelius, 2000) and this approach is probably dominant in 'mainstream' health psychology today (Crossley, 2001b).

All of the documents included aspects of bio-medical framing, and include, to differing degrees, aspects of psycho-social framing. The inclusion of both biological and psycho-social factors was specifically stated in the MACGLH document:

Sexual orientation and gender identity interact with other social and biological processes, to produce patterns of illness specific to each of these groups. (Ministerial Advisory Committee on Gay and Lesbian Health)

One notable feature of this is the way the group and the individual were conflated. The processes/issues discussed are specific to individuals, but the outcome is seen to be at the group level.

However, the inclusion of psychological and social aspects does not necessarily come at the expense of the biological. Within the documents that identify an integrated approach, the influence of genetics was apparent:

There are major factors that influence, in a positive or negative manner, health or well-being. One of these factors, genetics, encompasses, in a varying or unique measure, the biological inheritance of the individual and possible predisposition to specific diseases or disorders (e.g., sickle cell anemia or Tay-Sachs disease). Heredity is considered the internal or host variable of health status. (Gay and Lesbian Medical Association)

Genetics was not however viewed in isolation or given prominence, but is located along with a concern for the environment (both physical and social), rather than given prominence:

Another major factor influencing health is the environment; this is characterized as external, in contrast to genetics as internal. (Gay and Lesbian Medical Association)

However, these were still essentially framed

as separate processes – one external, one internal – which ignored the interactive effect of 'outside' on 'inside' and vice versa.

It is also worth discussing the relationship between the scope of health in the documents, and the reported 'community' input into developing the documents. As noted earlier, a lack of input does not necessarily result in a bio-medical framing of gay men's health. The AuMA document, which reported no community input, reflected a more holistic focus, along with the biomedical dimensions. It provided recognition of some of the wider community issues affecting gay men's health, such as heterosexism and homophobia:

The common experience of discrimination means the health of GLBTI populations differs from that of the general population. The discrimination leads to health problems that are shared by this group as well as health problems specific to each subgroup. (Australian Medical Association)

However the impact of cultural and social factors upon gay men's health were left underdeveloped in all of the documents, and when they did deal with these factors, they mostly focused on the health-limiting effects of interpersonal discrimination. They were not critically developed to explore wider political and economic aspects of social organisations that might affect the health of gay men.

While it is not possible to precisely determine the influence of gay voices in the formulation of the documents, in the two documents where specific gay input was acknowledged (GLMA, MACGLH), there was some consideration of wider psycho-social factors, for example, socio-economic status, geographic location, ethnicity were factors identified in the MACGLH document.

In summary, gay men's health was framed in two ways which mirror dominant and competing models of health: the biomedical, and the biopsychosocial. While the biopsychosocial model offers a fuller appreciation of factors

affecting health and health practices, there are nevertheless debates (e.g., Crossley, 2001b, 2001d; Nicolson, 2001; Owens, 2001) and critiques within [health] psychology (e.g., Marks, 1996, 2002; Stainton Rogers, 1996) about the appropriateness of the biopsychosocial model. These critiques question the prioritising of positivism and the scientific method (Stainton Rogers, 1996) and the "quantification of subjective areas of health and illness" (Crossley, 2001b: 243). Marks (1996) also identified a tendency to fail to pay adequate attention to "cultural, sociopolitical and economic conditions which set the context for individual health experience and behaviour" (Marks, 1996: 7). Using this critical framework, key absences in these constructions of gay men's health become obvious. The documents, for example, failed to explore gay men's health as a personal, cultural and social phenomenon (Watson, 1998, 2000), and there was an absence of knowledge grounded in the everyday experiences of men themselves (Watson, 2000).

### **Roles and Responsibilities**

Each construction of health has implications for gay men's health and healthcare provision, not least through the roles and responsibilities that are explicit and implicit. Approaching gay men's health from within a biomedical paradigm is likely to result in particular outcomes focusing on the clinical treatment of gay patients to improve their health. Within the clinical setting, and in medicine in general, the doctor – patient relationship is central, with the doctor being the dominant person (Murray & Chamberlain, 2000). Framing health within a biopsychosocial model allows the actions of the patients to be seen as (at least as) important as the actions of health professionals (Pincus, 2000). In this section we discuss how different constructions of health potentially impact on the role of the medical profession (and gay men) in gay men's health.

In both the AMA and APHA documents, the health of gay men was framed primarily as a medical responsibility, albeit with the help of

the gay community. Doctors were positioned as the appropriate people to obtain necessary information from the patient, and to identify and remedy the 'deficits'.

Patients usually feel at ease talking with their physicians about sexual practices and believe it is appropriate for physicians to question them in this area. (American Medical Association)

By recommending this sort of practice, doctors were positioned (and reinforced) as being in the role of 'experts' in gay men's health, through the taking of specific information (e.g., sexual histories), and thus their knowledge was implicitly privileged over the experiences and 'lay knowledges' of the gay men in this framework (recognising that the categories 'gay man' and 'medical professional' do also overlap, and some men are both). However, gay men were seen as having a role in facilitating this doctor – patient relationship.

With the help of the gay and lesbian community and through a cooperative effort between the physician and the homosexual patient, effective progress can be made in treating the medical needs of this particular segment of the population. (American Medical Association)

This strategy of involving 'citizens' in improving their health and wellbeing – in this case the gay and lesbian community – is very much part of consumer movements in health and the 'new' public health approach (Lupton & Peterson, 1996). It is seen as an important viable strategy for reducing professional ignorance, and building self aware practitioners, just as similar moves in ethnic cultural settings have been (e.g., Cram, Smith, & Johnstone, 2003; Kearns, 1997; Papps & Ramsden, 1996). However, there are pitfalls and few simple solutions. Building cultural awareness and sensitivity is not the end of this journey – the end is reaching cultural safety, a situation where 'trust' has been formed and becomes recognisable and tangible to patients and clinicians (Ramsden, 2002) and where self-aware practitioners are able to "practise in a culturally safe manner, as defined by the recipients

of their care" (Nursing Council of New Zealand, 2002: 12). This idea of 'culture' extends beyond ethnically-defined culture; to include things like sexuality-based culture (e.g., McNair, 2003). In the AMA document, multiple gay and lesbian communities and networks were conflated to one community – erroneously suggesting that cultural safety issues for members of diverse communities are (necessarily) the same. Collaboration with the community is however only a partial strategy, and experience from cultural safety in ethnic cultural settings is that community level involvement alone cannot improve the intervention for individual patients – appropriate practice from clinicians is also required.

Within the documents, medical practitioners were positioned as potentially failing to meet the needs of their clients. The AMA document noted that physicians often express discomfort with treating gay men. It was suggested that physicians needed to address this issue through better clinical practice/technique and improving attitudes towards patients – essentially issues of cultural safety:

... during the sexual history of gay men, lesbians, and bisexuals, the physician should ask questions about sexual abuse and domestic violence, just as with heterosexual patients.  
(American Medical Association)

By expressing a non-judgemental attitude toward gay men and lesbians, physicians can learn more about their homosexual patients, enhance rapport with these individuals, and provide optimal medical care to those in need.  
(American Medical Association)

The implicitly heterosexual physician was positioned as needing to be non-judgemental and equitable in treatment of all patients for the purpose of developing better clinical and other care for LGBT patients. These things were framed as being interrelated – the clinician could learn how to present a better attitude – and this would result in better practice. However, this was located purely at the 'surface-level' of the clinical encounter – no broader individual or social change was suggested.

This kind of instrumental rapport building is potentially subject to negative interpretation by gay clients/patients. It may also work to reinforce the heteronormativity of medical practice by categorising gay patients as people with 'knowable characteristics' who can be dealt with by practitioners who only need to deal with those 'certain properties' of the patient, and not with the individual characteristics of the patient (Hicks & Watson, 2003), meaning that the health care provision is not focused on the particular requirements of the patient.

Even in the documents which framed health more broadly than biomedicine, the role of the medical practitioners remains important.

Medical practitioners have a high status in society and their views carry much authority. They therefore have a role to play in promoting acceptance of sexual and gender diversity.  
(Australian Medical Association)

However, rather than this role for medical practitioners focusing on the clinical relationship – doctors were positioned (as a result of their authority arising from their high status in society) as having a role in creating and modifying the social environment, and in particular intervening to prevent heterosexism and homophobia. For instance, the AuMA highlighted the role of professionals in the destigmatisation of homosexuality:

In 1973 the American Psychiatric Association removed homosexuality from the Diagnostic and Statistical Manual of Mental Disorders. Subsequently homosexuality was recognised as a form of sexual expression rather than a mental illness. This move by the medical profession was instrumental in improving the health and welfare of this population. (Australian Medical Association)

Here the medical profession was represented as having a crucial role in changing the DSM and thus as promoting broader social acceptance and destigmatisation of homosexuality. However, this account of the 'positive influence' of the medical profession in removing

homosexuality from the DSM is only one version of the event, and one which presents the medical profession positively. The positive spin is in part challenged by the maintenance of homosexuality as a disorder in the *International Classification for Diseases* until 1992 (Warwick & Aggleton, 2002) – almost 20 years later, and the continued interest with the 'gay gene' (Brookey, 2002). It is also challenged by a range of research reporting the negative experiences gay men still face when seeking medical and health care (e.g., Beehler, 2001; Eliason & Schope, 2001; Plummer, 1999; Taylor & Robertson, 1994).

However, it is worth noting that it is not only the medical professionals who were positioned as having responsibility for the health of gay men – gay men were also positioned as having health responsibilities. And along with this construction, comes the risk that the individual will not recognise, or will fail to act on, the 'health risk'. The APHA document, for instance, recognised that:

... lesbians, gay men, bisexuals, and transsexual people may not see themselves at risk for many health problems and that health care providers may not identify and successfully diagnose them resulting in inadequate treatment. (American Public Health Association)

This description positioned LGBT persons in opposition to an implicit ideal (healthy) individual – someone who knows risks, reduces risk and seeks appropriate help when needed – framing them as potentially doing none of these things. Within this construction of health and healthy behaviour, then, there is potential for some subtle blaming of gay men for some of their health problems. The documents assumed that gay men are 'rational' and wanting to pursue improved health. This construction of the rational subject fails to recognise the complex psychological meanings and functions that are incorporated in health related behaviours (Crossley, 2001e), and offers no acknowledgement of the validity of 'risky health practices' within some gay men's lives (Crossley, 2001a).

In summary, these documents – unsurprisingly – identified a central role for medical practitioners, regardless of how health is framed. In the documents with a biomedical approach, this role was focussed on the clinical relationship. Within the documents employing biopsychosocial models, medical practitioners, because of their status in society, were seen as able to play a role wider than the clinical function – for example, in creating particular (supportive) social environments. There is no doubt of the desirability of having 'culturally safe' practitioners available for gay patients, and especially gay practitioners, and these practitioners are also likely to be in a position to be one of the parties who can contribute to improving social environments.

### **Implications: Moving Gay Men's Health Forward**

On the whole, public health and other population based approaches to health have tended to be 'broad brush' and this has resulted in a silence, or at best a limited development, of gay concerns in 'mainstream' health and well-being research and policy development (Dean et al., 2000). However, increasingly there is recognition of the specific health needs that gay men have, and it is these emerging responses that we have reviewed. The policies contained in the documents of the five organisations reviewed in this paper all recognised biomedical aspects of health, and incorporated psycho-social factors to differing degrees. The documents focused on deficits in the population of gay men, with either a disease orientation, or a combination of a disease orientation and a risk factor approach. Antonovsky (1996) argued such an approach focusing on pathogens and risk factors is narrow and limiting, and that what is needed is a *salutogenic* approach, independent of biomedicine, which *actively* promotes wellbeing (including 'well-health') and seeks to move the population along a health/dis-ease continuum to produce health gains. The documents all identified a central role for medical practitioners – and this was consistent with the biomedical aspects apparent in all the documents. The involve-



ment of gay men, organisations and communities was apparent in only two documents – and in both of these psycho-social factors were noted.

In four of the documents (APHA excluded), the concern with LGBT health was typically highlighted by deficits that have been identified through 'empirical research' that is increasingly being undertaken within many health areas and in many countries. However, much of the available research remains based on unrepresentative samples, meaning that there is often very little robust knowledge about homosexual experience, practice and identity available to researchers.<sup>8</sup> Although a body of research knowledge (much of it conducted within psychology) is emerging, there remains a lack of scientific information about gay men's unique health issues. Sell and Becker (2001) identified this as one of the greatest threats to gay men's health, particularly as the lack of well researched data and published reports makes it difficult to raise awareness of issues and acquire the resources necessary to address the issues. Similar arguments have been made by other researchers and gay community organisations who have noted that "the limited nature of research about gay populations makes it difficult to prioritize their health needs" (Gay and Lesbian Medical Association and LGBT health experts, 2001, p. 19). This has resulted in many calls for more and methodologically sound research on gay health issues (Hicks & Watson, 2003; L.A. Gay & Lesbian Center, 2002). While such information may be used for raising awareness around health matters, we need to acknowledge that the positivist-empiricist paradigm reinforces and privileges one form of knowledge at the expense of other alternatives and perspectives (Clarke, 2000; Kitzinger, 1990). Authors such as Clarke and Kitzinger have pointed out that the reinforcement of science as the means to define reality is not necessarily unequivocally 'good' to LGBTI people (see also Riggs, 2004).

Effective health promotion for any group is dependent upon a detailed understanding of

their culture and social practices, and therefore future research on gay men's health issues and associated policy development and practice outcomes will need to acknowledge the diversity within contemporary gay men's lives (Rofes, 1998), and should seek to privilege gay men's experience and knowledge in the research processes. Gay men's experience is critical to inform the future research endeavours and subsequent health promotion strategies. More sophisticated understandings of gay men's cultures in relation to health and masculinity will enable the development and refinement of tailored, population-level health promotion strategies and environmental interventions aimed at improving the health and wellbeing of gay men. Thus, as well as taking gay men's experiences into account, the ideas and understandings of gay men around health (including risk) need to be considered. This may not be as uncomplicated as expected, particularly as competing agendas between the professional/government 'experts' and the 'lay communities' (Crossley, 2001a) will potentially produce different responses to health issues (e.g., Crossley, 2001c). In the area of safer sex, for instance, Crossley (2002) pointed to "an increasingly emergent discourse of 'resistance' to health promotion and safe sex among gay communities" (p.65), which troubles the idea that all individuals will automatically seek or want the most 'healthy' practice and indeed outcome. Some gay men for example have eroticised deliberate HIV infection, with 'barebackers' (men who make conscious decisions to have unsafe anal sex) claiming that barebacking is a new form of self expression (Farber, cited in Crossley, 2002) and that having HIV confers a 'red badge of courage' and is a way of making you 'gayer' (Gross, 1993). Research has also found that men who report barebacking also report benefits associated with this behaviour, "including feelings of connectedness, intimacy, and masculinity" (Halkitis, Parsons, & Wilton, 2003, p.335).<sup>9</sup>

While there is undoubtedly a need for better information about the health needs of gay men, Wilkinson (2000), in her discussion

about women's health (which also apply to issues around gay men's health), suggested that theoretical and methodological eclecticism is needed. While the positivist empiricist research tradition is likely to be useful to answer some very particular types of questions, she has suggested that in order to improve it will be necessary to adopt a range of methods to address other questions. In particular, there is a call to ensure qualitative research supports quantitative work (Lee, 2000; Smith, Rissel, Richters, Grulich, & de Visser, 2003). There are limitations in seeking answers only through quantitative/positivist research and providing public health solutions only through 'meta-solutions'. This is clearly evidenced by the multidisciplinary research programmes being undertaken to understand health issues around HIV/AIDS (e.g., Australian Research Centre in Sex, Health and Society and Sigma Research).<sup>10</sup> This suggests that gay men's health issues need research that teases out the complexities of gay men's health and explores the everyday experiences of gay men, and particularly their health promoting behaviours. Such research will need to recognise multiple gay and lesbian communities, and will probably entail the disaggregation of gay and lesbian health issues (Wilkinson, 2002).

We agree with Warwick and Aggleton (2002) that research requires a strategic aspiration of doing more than explaining social life, it needs "to change social understanding and social reality by addressing issues of prejudice, discrimination, deliberate 'mis-understanding', inequality and power" (Warwick & Aggleton, 2002: 149). Research on gay issues occupies a contested political space. While in parts of Australia there appears to be a supportive environment for gay health research and policy development (e.g., Leonard, 2002; Ministerial Advisory Committee on Gay and Lesbian Health, 2002b), in the USA there has recently been concern and protest about the censorship and monitoring of gay health research (Gay and Lesbian Medical Association, 2003; Kaiser, 2003) and the dismantling of gay-focused health care initiatives (Gay and Lesbian Medical Association, 2002; Ornstein,

2003; Russell, 2003). Critical examination of straight cultures is also needed to better understand the existence and prevalence of discriminatory practices and discourses that work against population-level improvement in gay men's (and LBT) health.<sup>11</sup> This requires identification of the contexts and processes within gay men's health is constituted. Such an approach will recognise the desirability for gay men's health to move beyond an almost exclusive focus on HIV/AIDS (Millan & Brown, 2002; Rofes, 2003).

## Notes

<sup>1</sup> For instance, there was vigorous debate (Division 44, 2000) leading to the 1973 removal of homosexuality from the APA's *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1974; Kitzinger & Coyle, 2002), and this undoubtedly impacted on the social construction of homosexuality. In addition, sex between men is essentially decriminalised (to varying degrees) in most western countries – in Aotearoa New Zealand, for instance, homosexual acts between men were decriminalised in 1986 and sexual orientation was included as a protected category under human rights legislation in 1993.

<sup>2</sup> Some national health behaviour surveys conducted by the Ministry of Health, Aotearoa New Zealand included questions about sexual orientation of respondents, and provided some epidemiological data about health practices of gay men. However, these questions have now been removed.

<sup>3</sup> Prior to this there have been a number of health responses within gay communities, e.g., early responses to HIV/AIDS were located in gay communities (Dowsett, 1998; Garnets & Kimmel, 1993; Lindberg & McMorland, 1996; Parkinson & Hughes, 1987), and more recently the emergence in the USA of 'Gay Men's Health Summits' for health advocates, organisers, activists, and researchers.

<sup>4</sup> Subsequent to the completion of this paper, we located an exploratory discussion paper reviewing Health Canada's approach to gay men and HIV which "aims to revitalize HIV-transmission prevention for gay men in Canada by re-positioning it within the context of their broader health issues – gay men's health" (Ryan & Chervin, 2000: 8). While the main focus of the paper was on reviewing models appropriate to HIV prevention, it noted that the move back to gay health is often positioned as a 'renewal' – acknowledging that many earlier health initiatives of gay community organisations were

necessarily redirected at the HIV/AIDS crisis.

<sup>5</sup> This wider research is being undertaken by the first author (PhD Candidate) and the other authors (Supervisors) at the Department of Psychology, The University of Auckland.

<sup>6</sup> A full list of participants is provided in the GLMA document.

<sup>7</sup> See <http://www.dhs.vic.gov.au/phd/macqlh>.

<sup>8</sup> For example, nationally representative data has only recently become available for Australia (Grulich, de Visser, Smith, Rissel, & Richters, 2003).

<sup>9</sup> For popular accounts of this phenomena see (Freeman, 2003) and *The Gift* (2002)

<sup>10</sup> See <http://www.latrobe.edu.au/arcs/hs/> & <http://www.sigmaresearch.org.uk/>

<sup>11</sup> Similar arguments for health in ethnic cultural settings have been made (McCreanor & Nairn, 2002a, 2002b).

### Author Note

This reprinted chapter was initially prepared for publication in 2003. Since that time, a number of other policy documents addressing the area of health for gay men have been identified. An analysis of those will be reported in Jeffery Adams' PhD thesis.

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## CHALLENGING HETERONORMATIVITY IN PSYCHOLOGICAL PRACTICE WITH LESBIAN, GAY AND BISEXUAL CLIENTS

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### Abstract

*The current study sought to test the effectiveness of a workshop for post-graduate clinical psychology students to develop their ability to work with lesbian, gay and bisexual (LGB) clients in an appropriate manner. Seven female participants completed the workshop and all assessments. The study incorporated a pre-test-post-test design, with assessments taking place before the workshop and one month after. Assessment was conducted primarily through a number of questionnaires assessing attitude, behavioural intention, cultural competence and knowledge in relation to LGB people. Short answer responses to a scenario depicting an interaction between a heterosexual clinical psychologist and a gay male client were also analysed. Significant changes were found in behavioural intention ( $p = .017$ ), cultural competence ( $p = .001$ ) and knowledge ( $p < .001$ ). Qualitative analysis of scenario responses identified a number of instances where learning of workshop material was apparent, although this was not reflected in a quantitative analysis. The workshop produced some promising results, but may require modification in future applications to improve its impact.*

Keywords: psychological practice, heteronormativity, lesbians, gay men, bisexual people

### Introduction

Western societies function through various social norms that represent assumptions about particular forms of category membership. One such norm is heterosexuality. The social norm of heterosexuality (or 'heteronormativity') pre-

sumes or attributes a heterosexual identity to all members of society, and furthermore, it presumes that heterosexual is the 'normal' sexuality from which all others deviate (Johnson, 2002; Simoni & Walters, 2001). Such presumptions can often result in lesbian, gay and bisexual (LGB) people (amongst others) experiencing marginalisation and disadvantage in their everyday lives. One specific example of this occurs when same-sex attracted people access professional services (e.g., psychological services) that are not sufficiently attuned to their needs (Herek, 1995; Stevens, 1995). A practitioner's presumption of a client's heterosexual identity may result in failure to adequately understand how normative assumptions contribute to the client's marginalisation, and thus prevent them from receiving optimal service. The current study therefore aimed to design, implement and assess a workshop for clinical psychology students that examined the impact of heteronormativity on psychological practice, to assist participants to provide more appropriate and inclusive psychological services to same-sex attracted clients.

Same-sex attracted clients may experience therapy as oppressive because 1) they have experienced prejudice and discrimination throughout their life and are therefore understandably wary or fearful of discrimination from the practitioner, 2) the practitioner is unaware of social norms that may contribute to cultural or experiential differences that impact upon psychological service provision, 3) the practitioner has low confidence in their ability to provide psychological services to LGB individuals in a culturally sensitive manner, or even 4) the practitioner is prejudiced against

same-sex attracted individuals and this impacts upon their practice. All such cases have the potential to severely limit the development of rapport between practitioner and client and thus may limit the effectiveness of psychological services.

Practitioners demonstrate competence in working with particular client groups through their awareness, knowledge, and ability to employ cultural sensitivity (Israel & Selvidge, 2003). Cultural competence must be addressed at all levels of service provision, from relevant governing legislation and institutional policy to administration and the approaches of individual practitioners. For practitioners, perhaps the most useful method of developing and furthering their cultural competence is to undertake training (Yutrzenka, 1995). The Australian Psychological Society (APS) has identified that practitioners must be able to work with LGB clients (amongst others) in a culturally competent manner (APS, 2000). The APS ethical guidelines for working with LGB clients recommend that practitioners undertake professional development and training on issues relevant to service provision to same-sex attracted individuals, and that university clinical psychology courses include material on providing culturally competent psychological services to same-sex attracted people. However, such material is not mandated for course accreditation (Australian Psychology Accreditation Council, 2005), and the extensive material (much of it mandatory) competing for inclusion within the limited space of clinical courses may preclude cultural competence training. Thus, many Australian psychology students may complete their undergraduate and post-graduate education without exposure to LGB-related issues, and may feel unprepared to work with these client populations.

Hence, there is a need for training programs for clinical psychology students that address the provision of culturally competent psychological services to same-sex attracted clients. Although some training packages addressing prejudice towards same-sex attracted individuals do exist (e.g., *BlockOut*, Miller & Ma-

hatmi, 1994; *Not Round Here*, Miller & Mahatmi, 2000; *Creating Safe Space for GLBTQ Youth*, Girl's Best Friend Foundation & Advocates for Youth, 2005), the following summary suggests they are not necessarily suitable for the specific purpose of training clinical psychology students.

Existing programs may be ill-suited to clinical training for several reasons. First, programs such as *BlockOut* and *Not Round Here* (Miller & Mahatmi, 1994; 2000) often tend to focus on overt prejudice, which may not be particularly useful for clinical psychology students. Research suggests that students aspiring to enter a helping profession typically hold progressive rather than prejudiced views against same-sex attracted people (Peel, 2002; though this may not always be the case for students in general; see Hinrichs & Rosenberg, 2002; Medley, 2005; Ellis, Kitzinger & Wilkinson, 2002). This is not to deny the existence of prejudice amongst psychology students (and psychologists), nor should it be presumed that students and practitioners with LGB-positive attitudes do not engage in heteronormative practices (Ellis et al., 2002; Tolley & Ranzijn, 2006). It is, however, important to recognise that most students will not demonstrate overt bias against same-sex attracted people. Thus a primary focus upon prejudice and homophobia may be perceived as accusatory and interfere with students' ability to engage with and learn from presented material.

Secondly, existing programs take an individualised focus to addressing prejudice. That is, they focus on the impact of direct actions by heterosexual individuals towards same-sex attracted people, and are thus aimed at helping dominant group members 'change their attitudes' by 'learning about the other'. This implies that anti-LGB prejudice is only enacted by 'bad homophobic people' and ignores the effect that living in a heteronormative society has on the lived experience of same-sex attracted people (Peel, 2002). It may be beneficial to instead focus on how heteronormativity functions to produce both privilege and disadvantage (i.e., unearned benefits that accrue to

heterosexual people through living in a heteronormative society but which are unavailable to same-sex attracted people), and how this may shape the experiences same-sex attracted clients bring to therapy.

Thirdly, existing programs do not focus on the specialised needs and concerns of practitioners working with LGB clients. Although some material will be relevant across disciplines, these programs do not offer clinical students any practical strategies for working with LGB clients or an opportunity to develop confidence in doing so. Thus, a program specifically designed for clinical psychology students would be more clinically relevant and directly address participants' concerns.

Finally, existing packages are often time intensive. For example, the *BlockOut* training program (Miller & Mahatmi, 1994) is delivered over a three-day weekend. Such time commitments may be unfeasible given the considerable workload of clinical psychology students, who may benefit from a shorter training package.

Extensive reviews of relevant literature, consultations with professionals in the field, and evaluations of existing programs underpin the design of the current workshop, which focused on the (often hidden or obscure) functions of heteronormativity and the multiple ways in which insufficient awareness of heteronormativity will impact upon psychological practice, regardless of the sexuality of the practitioner. Furthermore, and with an understanding of heteronormativity as the broader framework in which psychological practice typically occurs, it is also important to examine the specific ways in which it is enacted.

Following Braun (2000), it may be suggested that heteronormativity takes places through the enactment of heterosexism (a term that incorporates the concept of normativity along with an understanding of discrimination based on sexual orientation). As Braun suggests, heterosexism can be understood to function through both commission and omission. The

latter refers to "the *lack* of disagreement with, or challenge to, heterosexist talk" (p. 136, original emphasis), such as a failure to challenge others' or one's own heterosexism. Braun defines the former as "the *explicit* articulation of heterosexist assumptions" (p. 134, original emphasis), such as assumptions regarding the gender of someone's partner. As this distinction suggests, that which is left unsaid can be just as damaging as that which is explicitly voiced. Such an approach that emphasises the often mundane ways in which heterosexism occurs may assist students to better understand the relevance of an approach to psychological practice that prioritises an awareness of heteronormativity in various forms (Peel, 2001).

Whilst the literature is relatively quiet on the design and process of sexuality-based cultural competence training (Van de Ven, 1995), a number of components are considered important (Peel, 2002; Phillips & Fischer, 1998), and have been incorporated into the workshop design. These include:

- identification of stereotypes and assumptions that participants may have regarding same-sex attracted individuals, and challenging these;
- experiential activities that help participants to understand the everyday experiences of same-sex attracted individuals, and through this;
- encouraging empathy;
- exposure to same-sex attracted people, either in person or through media such as videos and documentaries;
- recognition of privilege accrued to heterosexual people but denied to same-sex attracted people through heteronormativity, and;
- identification of practical strategies to help challenge heterosexism and heteronormativity and provide a more culturally competent service to same-sex attracted clients.

The workshop was designed to incorporate all of the above points, through both theoretical

components and exercises, and included information specifically relevant and useful to clinical psychologists and students. Discussion accompanied all components and exercises to help participants draw out relevant points in each section. Components included the use of terminology, assumptions and stereotypes, the impact of social norms, the effects of heteronormativity, practical suggestions and useful referrals.

A scenario exercise was developed to open the workshop. The scenario depicted an interaction between a heterosexual practitioner and a gay male client in a therapeutic context, and included a number of occasions where the practitioner's innocent but naïve dialogue potentially impacted negatively upon the client. Accompanying questions allowed participants the opportunity to discuss how this may be experienced as oppressive and alternative ways to approach the situation. Thus the scenario encouraged participants to consider how social norms surrounding sexuality promote certain stereotypes and assumptions, which may influence psychological practice and impact upon same-sex attracted clients.

The second exercise, the *Heterosexuality Questionnaire* (Rochlin, 1992), provided an example of how heteronormativity functions by reversing questions that are commonly asked of LGB individuals to instead question those who identify as heterosexual. This demonstrated how social norms around sexuality construct such questions as natural and legitimate and illustrated the effect such questions may have on same-sex attracted clients. For example, responding to "When and how did you first decide that you were a heterosexual?" required participants to justify their sexuality, which highlights for participants how same-sex attracted people may find this confronting and how heterosexuality does not usually require justification.

Despite psychology's commitment to support of LGB issues, heteronormativity remains present within the discipline and the way ideas

and information are communicated in psychological circles (Barker, 2007; Clark & Serovich, 1997; Hogben & Waterman, 1997; Myerson, Crawley, Anstey, Kessler, & Okopny, 2007; Simoni, 1996). Journal articles and textbooks provide central routes for dissemination of psychological knowledge, and the heteronormativity within these texts is thus conveyed to psychology students. The *Textbook* exercise required participants to search through prominent psychological textbooks to locate depictions of heterosexual and same-sex attraction within psychology textbooks, examine how they are represented within this context, and discuss in relation to heteronormativity.

The *Stepping Out* exercise (Ollis, Watson, Mitchell & Rosenthal, 2000) provided an experiential understanding of how social norms surrounding sexuality may impact upon the everyday lives of same-sex attracted people, and how these may differ from the lives of heterosexual people. This was achieved through matched scenarios that were identical except for the sexuality of the individual depicted. Participants responded to questions (e.g., "Can you kiss or hold hands with your partner in a public place, such as a Rundle Mall?") from the perspective of the depicted individual and differences in responses were used to demonstrate how heteronormativity impacts upon the daily lives of same-sex attracted people.

Participants also viewed 24 minutes of *Out in the Bush*, a video depicting young people talking articulately about their experiences of growing up same-sex attracted in rural Australia. This allowed participants to hear first-hand the impact of anti-LGB prejudice on these people's lives. Viewing was followed with discussion of issues raised by the video.

The workshop was also supplemented by two articles to be read independently. The APS *Guidelines for psychological practice with lesbian, gay and bisexual clients* (2000) was provided before the workshop to ensure that participants were aware of the basic ethical

requirement when working with same-sex attracted clients. A second reading (Hegarty, Pratto, & Lemieux, 2004) was provided after the workshop to further demonstrate how heteronormativity may operate in everyday interactions.

Traditionally, the effectiveness of sexual identity-based cultural competence programs has been operationalised as participants' attitude change towards same-sex attracted people, assessed through questionnaires (Herek, 1984). However, as previously discussed, postgraduate clinical psychology students may largely hold positive attitudes towards same-sex attracted people (especially those who self-select to attend a workshop on working with same-sex attracted clients). Thus the program in a sense may be 'preaching to the converted' (Peel, 2002). Consequently, results assessed in this matter may be subject to ceiling effects with little room for positive change.

Also, as attitudes are seen to be relatively stable, a single session workshop may not significantly alter attitudes. As such, attitude change may not be useful in assessing the efficacy of the workshop. Of greater relevance would be changes in participants' approach to interacting with same-sex attracted people, and their ability to do so in an appropriate manner. Hence, the assessment of behaviour (or more precisely, intentions for future behaviour) and cultural competence (operationalised in this study as self-rated skills and awareness of stereotypes and discrimination) as dependent variables would provide more useful information. Attitude may still be important, however, as the utility of the workshop may not generalise to populations that hold less positive attitudes towards same-sex attracted people.

Participants may perceive some social pressure to respond in ways that reflect positive attitudes or actions towards same-sex attracted people (as prejudice is inconsistent with psychological practice). They may also consider it socially desirable to be confident

and willing to provide such services. Demand effects may also occur, as the workshop is explicit in its aim of improving participants' confidence and comfort in working with same-sex attracted clients. Thus dependent variables that are less susceptible to social desirability and demand effects, such as knowledge, would also provide valuable information.

Thus it was predicted that implementation of the workshop would impact upon participants such that follow-up behavioural intention, cultural competence and knowledge scores would be higher than the corresponding baseline scores, and that these changes will manifest in the improved ability of participants to recognise heteronormativity in clinical practice and its impact upon clients, and subsequently change their evaluation of the psychologist/client interaction. Follow-up scenario response scores would thus be significantly higher than baseline scores.

## **Method**

### *Participants*

Three workshops were conducted, later workshops being added to increase the sample size, as workshop attendance was quite low (group sizes ranged from two to three participants). A total of eight female postgraduate clinical psychology students range in age from 23-53 years ( $M = 31.63$ ,  $SD = 11.49$ ) participated voluntarily. Seven participants completed the follow-up assessment, and the results are presented for these participants only.

### *Design*

The study employed a pre-test/post-test design. Baseline assessments were completed during the week before the workshop, except for scenario responses, which were completed as the first exercise of the workshop. Follow-up assessment occurred one month following the workshop. The dependent variables were attitude, behavioural intention, cultural competence, and knowledge in relation to same-

sex attraction and responses to the workshop scenario questions.

### *Measures*

Attitude was assessed through an adapted version of the *Index of Attitudes Towards Homosexuals* (IATH; Hudson & Rickets, 1980), a 25-item self-rated standardised measure of attitude towards same-sex attracted people. The IATH demonstrated high internal reliability within this study (Cronbach's  $\alpha = .95$ ). Participants responded to statements such as "I would feel comfortable working closely with a lesbian", and "I would feel uncomfortable knowing that my son's teacher was a gay man" on a 7-point Likert scale. Responses were averaged for a total score ranging from 1-7, with higher scores reflecting more positive attitudes.

Behavioural intention was assessed through an adapted version of the *Homophobic Behavior of Students Scale* (HBSS; Van de Ven, Bornholt & Bailey, 1996), a 10-item self-rated standardised measure of willingness to interact with same-sex attracted individuals. The HBSS demonstrated high internal reliability ( $\alpha = .87$ ) within this study. Participants responded to statements such as "I would speak individually, in class, with a lesbian, gay or bisexual person about same-sex attraction issues" on a 7-point Likert scale. Responses were averaged for a total score ranging from 1-7, with higher scores reflecting greater willingness. Seven additional items were generated to assess participants' approach to working with same-sex attracted clients in a therapeutic context, for example, "I am looking forward to providing psychological services to same-sex attracted people". The internal reliability of these added questions was also high ( $\alpha = .85$ ).

Cultural competence was assessed through the *Sexual Orientation Counselor Competency Scale* (SOCCS; Bidell, 2003) a 29-item self-rated standardised measure comprised of three subscales: Awareness, Skills and Knowledge. The SOCCS demonstrated high internal

reliability overall ( $\alpha = .82$ ). The 10-item Awareness subscale assessed participants' approach to working with same-sex attracted clients, including an awareness of assumptions and stereotypes and how they may impact upon same-sex attracted clients (e.g., "It would be best if my clients viewed a heterosexual lifestyle as ideal" – reverse scored), Internal reliability of this subscale was poor ( $\alpha = .45$ ), though this may merely reflect low variance among the very high scores. The 12-item Skills subscale ( $\alpha = .88$ ) assessed participants' perception of their own skills and their training in providing services to same-sex attracted clients (e.g., "I feel confident to assess the mental health needs of a person who is LGBT in a therapeutic setting"). The 7-item Knowledge subscale ( $\alpha = .66$ ) assessed understanding of specific issues and difficulties that same-sex attracted people may face, particularly in accessing psychological services (e.g., "Heterosexist and prejudicial concepts have permeated the mental health professions"). Participants responded on a 7-point Likert-type scale (1 = not at all true, 7 = totally true), with responses averaged so that subscale and total scores range from 1-7, with higher scores reflecting greater competence.

The *Knowledge about Homosexuality Questionnaire* (KAHQ; Harris, Nightengale & Owen, 1995) is a 16-item standardised measure of factual knowledge. It assessed participants' acceptance of (incorrect) stereotypes of same-sex attracted people (e.g., "A majority of same-sex attracted people were seduced in adolescence by a person of the same sex, usually several years older") and knowledge of LGBT culture and other information related to non-heterosexuality (e.g., "'Coming out' is a term that lesbian, gay and bisexual people use for publicly acknowledging their same-sex attraction"). Ten added items reflected knowledge of rights and legal protections of same-sex attracted people within Australia ("e.g., In South Australia, the same-sex partner of a deceased person can legally be denied access to their funeral"). Participants responded to items with 'true', 'false' or 'unsure' according to their own knowledge, with correct re-

sponses scored as one and other responses scored as zero. The range of possible total scores was thus 0-26.

All above measures were adapted through changes to terminology to ensure that they were respectful of same-sex attracted people. This was done particularly in relation to the term 'homosexual', a label that has been criticised and rejected by many within LGB communities (Kitzinger, 1987), and recognised as problematic by the American Psychological Association (2001). The term 'homosexual' was replaced with 'gay man', or when it is used more generally, with 'same-sex attracted'.

The opening scenario of the workshop was developed both as a learning tool and as an opportunity for participants to demonstrate (measurable) awareness of issues relevant to culturally competent practice with LGB clients. The depicted interaction between practitioner and client was divided into three parts interspersed with short-answer questions assessing participants' ability to recognise examples of heteronormativity (e.g., "Why might the psychologist have assumed that [the client] was heterosexual?"), identify the expression of stereotypes and assumptions ("What stereotypes(s) does the psychologist appear to be drawing upon?"), and articulate how and why these might impact upon the client ("How might this exchange have influenced the session?"). Participants responded to eight short-answer question and two items based on a 1-7 Likert scale. The internal reliability of scenario responses was acceptable ( $\alpha = .64$ ). Each relevant point for short-answer responses were scored as one, the maximum score for each item being the highest number of points that could be reasonably made for that item, with a possible range of 0-50. Two raters independently scored short-answer responses, with discrepancies resolved through negotiation. The text of short-answer responses was also analysed to identify conceptual changes that may not necessarily have been reflected in numerical coding.

### Procedure

Potential participants were notified of the workshop through leaflets and emails, and interested parties were provided with an introduction letter, consent form, and questionnaire measures to be completed and returned prior to the workshop. Once participants returned baseline questionnaires, they received a copy of the APS *Guidelines for psychological practice with lesbian, gay and bisexual clients* (2000) as an introductory reading. Participants attended the 3-hour workshop, the first activity being the aforementioned scenario from which ability related responses were taken. Upon conclusion of the workshop, participants were provided with an article of further reading (Hegarty et al., 2004) to supplement training. Follow-up assessment was conducted by mail one month after the workshop.

### Results

The descriptive and inferential statistics for all dependent variables are presented in Table 1, and demonstrate positive change in some of the measures. Behavioural intention (HBSS) scores were moderately high at baseline and in the high range at follow-up, and this increase was significant ( $p = .017$ ) improvement. Scores for the additional therapy specific behavioural items were initially slightly lower than for the overall measure, however the significant ( $p = .016$ ) improvement for these items was somewhat more pronounced. Thus, participants were generally willing to work and interact with LGB people and clients, and this willingness increased following the workshop.

Similar results occurred for self-rated cultural competence as measured by the SOCCS. The moderate scores at baseline increased significantly ( $p = .001$ ) to moderately high scores at follow-up. This change was caused by increases in the moderately low scores of the Skills ( $p = .002$ ) and Knowledge ( $p = .012$ ) subscales to more mid-range scores. There was no change in Awareness subscale scores



Table 1. Descriptive and inferential statistics for baseline and follow-up assessments

| Variable                     | Baseline<br><i>M</i> ( <i>SD</i> ) | Follow-Up<br><i>M</i> ( <i>SD</i> ) | Baseline<br>Range | Follow-Up<br>Range | <i>t</i> | <i>p</i> |
|------------------------------|------------------------------------|-------------------------------------|-------------------|--------------------|----------|----------|
| LGB Attitude (IATH)          | 6.07 (0.94)                        | 6.12 (0.85)                         | 4.44-6.96         | 4.84-6.84          | -0.34    | .749     |
| Behavioural Intention (HBSS) | 5.76 (0.66)                        | 6.22 (0.58)                         | 4.71-6.41         | 5.47-6.94          | -3.27    | .017     |
| Therapy Specific Items       | 4.96 (1.02)                        | 5.90 (0.72)                         | 3.71-6.14         | 5.00-6.86          | -3.31    | .016     |
| Cultural Competence (SOCCS)  | 4.18 (0.54)                        | 4.77 (0.55)                         | 3.72-5.21         | 3.90-5.76          | -5.62    | .001     |
| Awareness Sub-scale          | 6.86 (0.14)                        | 6.81 (0.18)                         | 6.70-7.00         | 6.50-7.00          | 0.89     | .407     |
| Skills Subscale              | 2.64 (1.32)                        | 3.61 (1.27)                         | 1.36-5.09         | 1.91-6.09          | -5.05    | .002     |
| Knowledge Sub-scale          | 2.95 (0.82)                        | 3.80 (0.62)                         | 1.75-3.88         | 3.00-4.63          | -3.57    | .012     |
| LGB Knowledge (KAHQ)         | 13.71<br>(2.06)                    | 17.71<br>(1.38)                     | 11.00-<br>17.00   | 16.00-<br>20.00    | -6.93    | <.001    |
| Scenario                     | 17.09<br>(2.80)                    | 19.11<br>(4.72)                     | 14.86-<br>21.14   | 17.14-<br>27.93    | -1.17    | .287     |

( $p = .407$ ), which were very high at both assessment points. Thus, whilst participants may have held an ideological stance appropriate for working with LGB clients (as indicated by high awareness scores), they may not have the experience, skills, or knowledge of issues facing same-sex attracted people required to do so most effectively. Both skills and knowledge were improved following the workshop, however there was ample room for further improvement

Knowledge scores as measured by the KAHQ also demonstrated significant improvement ( $p < .001$ ). At baseline, participants on average answered about half (52.7%) of the items correctly and this increased to about two thirds (68.1%) of items answered correctly at follow-up.

Not all measures demonstrated significant

changes. Attitude (IATH) scores ( $p = .749$ ) were high at both baseline and follow-up. Thus, as expected, participants demonstrated a positive attitude towards LGB people that was unaffected by the workshop. In contrast, baseline scenario response scores were low, with no significant change in scores following the workshop ( $p = .287$ ). When numerical coding was applied to short-answer scenario responses, the workshop largely failed to effect any change in the ability to identify heteronormativity and its effect on LGB clients. However, coding written responses necessarily simplifies the data, possibly causing useful information to be lost. Examination of matched baseline and follow-up responses from individual participants highlights that some participants indeed modified follow-up responses to reflect development in understanding workshop concepts. Table 2 presents five such instances.

Table 2. Sample baseline and follow-up short-answer responses to scenario items

|   | Question  | Baseline Response  | Follow-Up Response   |
|---|---|--|--|
| 1 | Can you think of some reasons why [the client] might have been agitated during the session? | Anxiety re: heterosexual psychologist, also general anxiety seeing a psychologist. | General agitation that any client may have when visiting a psychologist for the first time. Marital status question may have alienated [the client] due to its hetero assumption.                        |
| 2 | What do you think of [the practitioner's] response?   | It was fine.   | [The practitioner's] response was somewhat inconsiderate, and it wasn't very sensitive to make the comparison between his relationship with his wife and [the client's] relationship with his boyfriend. |
| 3 | [the participant discusses the client's reaction to the practitioner's assumption]          | ...having always to explain that you are different.                                | years of having to deal with being in a minority group and interacting with a world that has a heterosexual bias and blindness to other forms of sexuality.  |
| 4 | What stereotype(s) does [the practitioner] appear to be drawing upon?                       | Unsure.  | That all gay people behave in a similar way (that is not like 'normal' guys).  |
| 5 | As above  | That being heterosexual is normal and that being gay is abnormal.                  | That all gay men are caught up with body image issues, and all gay men are the same and not individuals.   |

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The participant in Example 1 initially provided a general (though equally valid) response, citing 'general anxiety' as a cause of the client's agitation. In contrast, their follow-up response identified one of the triggers embedded within the scenario, namely the inherent heteronormativity within a questionnaire provided to the client. This indicates some learning of the implicit manifestations of heterosexism (Braun's, 2000, 'heterosexism by omission') from the workshop.

In Example 2, the participant critiqued the practitioner's assumption of the client's heterosexuality, and his response when informed otherwise. Whilst the baseline response accepts the practitioner's heteronormative assumption and reaction to being corrected, the follow-up response clearly identifies the inappropriateness of comparing heterosexual and same-sex relationships, which minimises or denies the significant differences between the

two in the context of a heteronormative society.

In response to the same question, the participant in Example 3 took the opportunity to describe the possible impact on the client. The baseline response suggested that it would be hard 'always having to explain you are different', which marks LGB people as 'different', and implicitly places heterosexuality as the norm they deviate from. The follow-up response demonstrated understanding of the concept of heteronormativity, identifying that being 'forced into difference' (Raymond, 1992) is the product of living in a world shaped by a 'heterosexual bias and blindness to other forms of sexuality'.

Examples 4 and 5 examined the stereotypes evident within the practitioner's assumption that most gay men are image conscious, and that by not matching stereotypes the client

was therefore 'just a normal guy' (i.e., unlike his assumptions as to what 'most gay men' are like). In Example 4 the participant was initially unable to identify *any* of the range of stereotypes utilised within the scenario. In contrast, the follow-up response identified both the problematic usage of the term 'normal' (indicated through quotation marks) and the assumption that gay men constitute a homogenous group, a stereotype that was directly challenged within the workshop. This aspect of learning from the workshop was also evident Example 5, even though the participant initially demonstrated a greater awareness of heteronormative stereotypes.

These five examples highlight that whilst the scenario measure did not produce statistically significant results, it provided opportunities for participants to demonstrate an understanding of heteronormativity and heterosexism that may be of clinical significance. The observed changes were often subtle and difficult to assess using numerical coding and may thus be more suited to qualitative analysis, as they may nonetheless have a significant impact on clients when used in clinical practice.

## Discussion

This study aimed to test the effectiveness of a workshop designed to enhance the ability of clinical psychology students to interact with LGB clients in a culturally appropriate manner. To do so, it was necessary to assess various aspects of cultural competence, including behavioural and knowledge based aspects, as well as practical components, such as using scenario responses to assess ability to recognise heteronormativity.

As predicted, behavioural intention, cultural competence and knowledge showed positive changes in scores. Despite initial behavioural intention scores indicating that participants were willing and comfortable about interacting and working with LGB clients, these scores still demonstrated an improvement at follow-up. This effect was more pronounced for items

that specifically focused on interaction in a therapeutic context, with mean changes for these items twice that of the overall measure. Thus, in terms of developing willingness and confidence in interacting with same-sex attracted people, the workshop appears to be effective, particularly in relation to clinical practice. Of course, it was beyond the scope of this study to determine whether these intentions translated into observable behavioural change.

Participants' cultural competence also improved following the workshop, although this was not true of all subscales of this measure. Participants' awareness of the heteronormativity exhibited in assumptions and stereotypes of non-heterosexuality and their effect on same-sex attracted people (Awareness subscale) was consistently high across assessment points, limiting the scope for improvement following the workshop. This sympathetic ideological position on sexuality contrasted with lower levels of knowledge and skills in working with LGB clients, as measured by the remaining subscales.

At baseline, participants generally rated their skills and experience in working with LGB clients (Skills subscale) as moderately poor, and also demonstrated poor knowledge of the difficulties LGB clients face in accessing psychological services. Whilst significant improvements were made in both these areas, and indeed exhibited the largest improvements among the Likert-based measures, mean scores for both subscales remained below the mid-point of 4 at follow-up assessment. This leaves substantial room for improvement in these important aspects of working with LGB clients. Future workshop versions may address this by including more experientially focussed exercises, such as role-plays.

The KAHQ assessed a more general knowledge of LGB-related issues, such as distinguishing fact from stereotype, queer culture and LGB rights in Australia. Participants' baseline responses demonstrated some initial

knowledge in these areas (52.7% correct), with a significant improvement at follow-up (68.1% correct). Whilst this change is promising, an average of one third incorrect responses leaves significant room for improvement.

Notably, these low to moderate cultural competence and knowledge scores occurred despite high attitude scores. This may imply that strongly sympathetic attitudes towards LGB clients notwithstanding, clinical students may not have acquired other skills required for working with LGB clients. Thus, an LGB-positive attitude, whilst necessary, is not sufficient for culturally competent clinical practice or for self-confidence in providing it.

The significant changes in behavioural intention, cultural competence and knowledge scores did not necessarily translate into an increase in participants' ability to implement these improvements, as is demonstrated by the absence of significant change in scenario scores. A number of explanations may account for this finding, the first being that the workshop may not have adequately conveyed material in a manner that facilitated engagement and understanding of key concepts. For example, the workshop focused on how heteronormativity acts to obscure the visibility of non-heterosexual identities and promotes the universality of heterosexuality. However, when asked why the practitioner may have assumed the client was heterosexual, participants generally responded that this was statistically more likely and made no reference to heteronormativity (although one participant did describe a 'heterosexual mindset', and other participants described heteronormativity in responses to other items).

Alternatively, the measure itself may not have provided participants with adequate opportunity to utilise concepts absorbed during the workshop. The scenario was not designed exclusively as an assessment tool, but doubled as a learning tool. Thus the dual application of the scenario may have unintentionally com-

promised measurement, particularly at the follow-up assessment, where learning was no longer a relevant function.

The environment within which participants responded to scenario items also requires consideration. Short-answer responses require greater intellectual exertion than Likert-based responses. Baseline responses were completed during the workshop, where participants were exposed to scrutiny from colleagues and the researcher, providing motivation to commit effort to the task. However, participants were free from scrutiny during follow-up, and may have experienced less motivation to provide considered, detailed responses. This explanation is consistent with the observation that many of the follow-up responses to scenario items were noticeably less detailed than at baseline.

Despite non-significant changes in response scores, an examination of short-answer responses identified several instances where participants demonstrated acquisition of knowledge presented within the workshop. This provides some evidence that the workshop can impart some learning that is useful within a clinical context.

Interpretation of this study should be made with reference to the following limitations. Without a control group the study was susceptible to a number of threats to internal validity, particularly expectancy and demand effects. Whilst the KAHQ and the scenario responses were included because they should be resistant to such effects, scenario responses did not demonstrate an improvement in scores. Future studies must be more carefully controlled to allow clear demonstration of effectiveness.

Whilst participants' LGB-positive attitudes were of course desirable, this may limit the study's generalisability. Students choosing not to attend the workshop may hold less positive attitudes, or be indifferent or unsympathetic towards same-sex attracted people. Indeed, the low level of interest in the workshop may indicate that LGB issues are of low importance

to a number of students, who thus arguably have a greater need to attend. This does not deny the possibility of other reasons for non-participation, including the heavy time commitments required of clinical psychology students. A number of students expressed interest in the workshop but cited (mostly study-related) commitments that prevented attendance. Even so, the workshop has thus only been tested for participants already sympathetic to LGB issues, and thus has not been able to demonstrate the capacity to engage with and achieve effective outcomes for less sympathetic students (although alternatively less sympathetic students may also have greater scope for increases in cultural competence).

Sample size was a significant limitation. Although the workshop was offered at a range of dates and times, few students expressed interest in participation. The study's design enabled significant results with a small sample, however future studies using more rigorous designs will require larger samples, and new recruitment strategies should be considered. Additionally, all participants were female, and thus results may not generalise to male students. This was not an intentional feature of this study; no males expressed interest in participation. Participants' sexual identity was not recorded, so neither can it be determined if sexuality influenced workshop outcomes.

The disappointing level of interest from potential participants may also be informative about the utility of a workshop as an educational tool for clinical psychology students. Even a highly effective workshop will have little impact if few students attend, and thus researchers and trainers may need to develop means to increase workshop participation, such as inclusion within coursework or incorporation of LGB issues within mainstream material. Alternatively, with professional development recently becoming mandatory for all APS members (Verbyla, 2007), there may be increased incentive or opportunity to conduct the workshop for practitioners.

This study sought to test the utility of a workshop designed specifically for clinical psychology students to increase their ability to provide psychological services to same-sex attracted clients in a culturally appropriate manner. Results demonstrate significant improvements in willingness to interact with LGB individuals and confidence in doing so in a clinical context. Low baseline levels of knowledge and cultural competence signal a need for such workshops and there were significant improvements in these areas, although considerable room for further improvement remained for some aspects of these outcomes. Participants already held LGB-positive attitudes and thus there was little scope for improvement, and the lack of significant change in scenario responses may be attributable to the failure of the workshop to adequately address relevant concepts, or to measurement issues.

Whilst the findings of this study are generally encouraging, the study's design does not exclude threats to internal validity, and thus future studies should seek to remedy this, and also address other issues highlighted in this study, such as methods for increasing participant numbers and diversity, and modifying workshop material for a stronger focus on skill and confidence acquisition. However, cultural competence may be considered an essential component of psychological practice, and the workshop is a significant development that focused on the specific needs of clinical students without the time commitment of other programs.

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## THE PSYCHONEUROIMMUNOLOGICAL DATABASE FOR PSYCHOLOGICAL INTERVENTIONS IN HIV INFECTION

PETER B. TODD

### Abstract

*The emergence of multiple drug resistant strains of HIV creates the need for a renewed focus upon the status of scientific knowledge concerning the impact of psychosocial and emotional factors upon immunity, disease progression and AIDS mortality in HIV seropositive persons. To this end, the field of psychoneuroimmunology (PNI) has provided a vast empirical data base of psychosocial determinants of immunity, illness progression and mortality in HIV infection since the early 1980's. Such data have demonstrated that psychosocial factors are highly significant predictors of behaviour known to enhance risk of exposure to HIV and therefore need to be considered as a vital foundation of primary prevention programs aiming to minimize new infection rates. This paper reviews the psychosocial factors already identified as significant to both primary and secondary prevention while outlining directions for future research, including the need for studies which permit the use of multivariate techniques such as hierarchical logistic regression and discriminant function analyses. Homophobia in particular seems to be a health menace as a determinant of high risk behaviour, immunosuppression and AIDS mortality. Cross cultural validation of research is emphasized as most PNI studies have been conducted in the developed world, especially North America.*

Keywords: psychoneuroimmunology, HIV

### Introduction

Kuhnian anomalies suggest the need for a paradigm shift in the scientific understanding

and treatment of HIV/AIDS. This may involve a move beyond the traditional medical model, and towards a multifactorial, ecological or holistic framework which highlights the potential efficacy of psychological interventions. The anomalies in the current paradigm include multiple drug resistance to HIV, resulting in potentially serious limits to a purely pharmacological approach to treatment with antiretroviral drugs. Rambaut, Posasa, Crandall and Holmes (2004) commented in their paper that the evolutionary significance of HIV and mutation was underestimated by those who proposed that highly active antiretroviral therapy (HAART) represented a cure for AIDS. Commenting upon the marked genetic variability exhibited within individual hosts, these authors referred to HIV as 'one of the fastest evolving of all organisms'.

Mathematical modelling which had predicted the eradication of virus from patients within two or three years has not been fulfilled. Yu and Weber (2006) observed that one of the most disturbing events in attempts to counter HIV infection has been the emergence of mutations that conferred resistance to all 20 FDA approved antiretroviral drugs then being used clinically. Further anomalies include the almost insuperable difficulties with vaccine development due to mutation reported by Ho (2005) and most recently, evidence of increased risk of seroconversion in one clinical trial reported by Kresege (2007). Alternative biomedical approaches to scientific understanding include the work of Davis (2006) and his colleagues exploring how HIV hijacks cellular communication networks to propel itself from one cell to another and the research of McFadden & Al-Khalili (1999) in developing a quantum me-



chanical model of 'adaptive' or directed mutation. This is particularly relevant in relation to mutant strains of tuberculosis, which in conjunction with HIV seropositive status constitutes a threat to the lives of millions of people, especially in the developing world. It is in the context of such anomalies in classical biomedical research that prioritizing empirical studies into psychoneuroimmunological aspects of HIV/AIDS and evaluating psychological interventions may need to be re-evaluated. HIV is a threat to both immunological and psychic identity and self-integration as well as biological survival and immortality.

### **Primary and Secondary Prevention**

Psychological interventions would aim to facilitate the modification of personality, stress, emotional and behavioural factors which enhance the probability of exposure to HIV as well as immunosuppression and disease progression once infection has occurred. In conjunction with education programs and biomedical measures demonstrated by empirical evidence to reduce the risk of infection, such measures fall into the domain of primary prevention. The rationalist assumption that simply providing information about behaviours resulting in a high risk of exposure to HIV is a sufficient primary prevention measure has been known to be flawed since the early 1980's (McKusick, 1983, Todd, 1992), while repeating the errors which have historically characterized attempts to modify behaviour patterns related to cancer and heart disease (Todd & Magarey 1978). The often complex and unconscious motivations of such high risk behaviours must also be taken into account. Similar considerations apply to behavioural and lifestyle factors such as substance misuse which are likely to impact upon immunity and disease progression once infection has occurred.

Evidence based psychological interventions are potentially highly relevant to immunosuppression (and enhancement) as well as disease progression in persons who are already seropositive to HIV (Solomon, 1987; 1991; Todd, 1992; Cole & Kemeny, 2001 and Kie-

colt-Glaser & McGuire, 2002). Empirical data concerning these issues fall into the domain of secondary prevention and much of the research on psychoneuroimmunological aspects of HIV/AIDS concerns quantified psychosocial factors predictive of immunity and disease outcome. In the remainder of this paper I shall review empirical studies relevant to both primary and secondary prevention as well as the implications for psychological interventions in considerable detail. Historically many studies had evaluated the relevance of one or few psychosocial factors instead of exploring the possible predictive significance of multiple variables with respect to immunity, illness outcome and AIDS mortality.

### **The Psychophysical Problem**

One conceptual obstacle to the acceptance of psychoneuroimmunological research has been a conscious or unconscious investment in a materialist epistemology of science. Reductionist materialism has viewed consciousness and mental processes as epiphenomenal and causally inefficacious by-products of events in the brain. Such a position either denies causal significance to psychological factors or regards mentalistic terms as a linguistic shorthand for the description of neurophysiological processes. Historically, this has been one influential solution to the so-called 'psychophysical' or mind/matter problem.

The contributions of such neuroscientists as Eccles (1990) and Pribram (2004) have challenged such mindless materialism, concluding that philosopher Karl Popper's three worlds of brain, culture and mind (Popper & Eccles, 1990) are indispensably necessary for the achievement of consciousness. The 'three worlds' interact in a feedback loop, so that consciousness or mind program the brain to evolve culture which in turn stimulates mental development. As Pribram (2004) pithily put it in referring to the mental, 'the more reflex the reflex, the less does mind accompany it'. Even sophisticated brain imaging techniques such as fMRI do not permit the prediction of the phenomenological content of consciousness.

Physicists as far back as Erwin Schrödinger (1992) and as recently as David Bohm (2002), Roger Penrose (2004), Basil Hiley and Paavo Pylkkänen (2005) have rejected the materialist reductionist perspective on mind as incompatible with a post classical physics and with quantum mechanics. They have argued instead for the adoption of a dual aspect relationship of 'complementarity' between mind and matter in considering the role of the observer. The mental has therefore become a reputable domain of scientific enquiry, with one potent source of resistance to psychosomatic research and psychoneuroimmunology being overcome. Making a move beyond pharmacology and the medical model plausible in the empirical understanding of HIV.

### **The Nature and History of Psychoneuroimmunology**

The late Professor George Solomon was an eminent scientist and pioneer, actually credited with coining the term 'psychoimmunology' in 1964. Solomon and Engel (1977), who had called for a revolution in scientific understanding due to research in the field of psychosomatic medicine, had seriously challenged the traditional Jenner-Pasteur model of infectious disease as well as such immunologically mediated and resisted illnesses as cancer and autoimmune disorders. Early correlational studies beginning in the 1930's on the basis of largely psychoanalytic insights into the impact of repressed conflicts in 'object relations' or attachments and about anger as well as the symbolic meanings of specific organ systems (such as the breast) had laid the foundations for psychosomatic hypotheses which, however, did not permit causal inferences to be made on the basis of data collected (Menninger, 1938; Grinker, 1973). The possible causal significance of psychological and social factors could be assessed only when the biological mechanisms mediating the impact of such variables on disease onset and outcome could be elucidated and quantified. Psychoneuroimmunology was born when both immunological and neuroendocrine pathways were

identified and became susceptible to empirical measurement. A landmark study was that of Bartrop (1977), an Australian physician who demonstrated depression of T lymphocytes after bereavement, a finding replicated by Schleifer, Keller, Camerino, Thornton and Stein (1983). Higher mortality rates in partners within 6 months of bereavement were observed.

The explanatory theoretical framework provided by Bowlby (1989) in his work on *Attachment and Loss* has been a useful source of hypotheses about the impact of bereavement and separation upon immunity and illness including HIV/AIDS. Bereavement resulting in guilt and self reproach is not only emotionally toxic, but like homophobia, deleterious to HIV seropositive persons as I shall point out in discussing psychosocial factors as predictors.

Solomon (1987), Ader (1981; 1991), and Todd, (1992) have provided detailed reviews of the nature and history of psychoneuroimmunology, including early studies of HIV/AIDS within this conceptual framework. Specifically, empirical research on psychosocial factors as predictors of behaviour patterns associated with the risk of infection with HIV, immune status and the onset of AIDS spectrum disorders in seropositive individuals were reviewed. I shall now turn to the psychosocial factors demonstrated to be predictors of immunosuppression, illness progression and AIDS mortality. Psychosocial factors have demonstrated significance for secondary prevention, that is to say, to influencing immunity, illness and AIDS related mortality even with the introduction and use of antiretroviral drugs, especially in the developed world. The results of intervention studies based on these data which appear promising will be discussed briefly in the next section.

### **Psychosocial Factors as Predictors**

Hypotheses about psychosocial factors likely to be relevant to the onset and progression of HIV/AIDS were deduced initially from research studies of the role of such factors in other im-

munologically mediated and resisted diseases including cancer, autoimmune disorders and infections such as Epstein-Barr, cytomegalovirus and herpes simplex. This work had been published in such sources as the volume of Ader (1981) on psychoneuroimmunology. Viral causation of certain cancers had been considered probable even prior to the onset of the HIV/AIDS pandemic during the early 1980's. Solomon (1987) and other members of the Biopsychosocial AIDS Project at the University of California, San Francisco including Todd (1986; 1992) formulated hypotheses about psychosocial factors as predictors of immunity and illness in HIV infected persons as well as the role of such factors as determinants of behaviour patterns resulting in a high risk of exposure to HIV. Solomon (1987) reported the results of pilot studies in the United States. Summed up briefly, the early hypotheses concerned the possible significance of such psychosocial factors as (a) coping and defence mechanisms, (b) loss of significant persons through bereavement or separation, (c) depression manifest as hopeless/helpless reactions to trauma and threat, as distinct from grief (d) Integration or acceptance of sexual identity, compared to internalized homophobia and shame, (e) inward-turning or suppressed anger, (f) social support and (g) resilience associated with a sense of meaning in life.

The pilot studies and early research reported by Solomon (1987; 1991) and Todd (1986) provided some significant data in support of these hypotheses. Internalized homophobia was significant in the work of both McKusick (1983) and Todd (1992) as a determinant of high risk behaviour with respect to HIV infection as well as immunosuppression and the onset of clinical symptoms of AIDS spectrum illness. However, the need for prospective, longitudinal studies and controlling for possible confounding factors such as substance misuse and with larger sample sizes to optimize statistical power, was noted by workers as an important direction for future research as well as more rigorous hypothesis testing (Solomon, 1991; Todd, 1992; Cole & Kemeny, 2001). Extensive reviews of studies on psy-

chosocial determinants of immune status and the progression of HIV infection since 1991 have been provided by Cole et al (2001) and Kiecolt-Glaser and McGuire (2002).

Factors which may have direct implications for interventions are now summarized. Analyses focussing upon reactions to highly traumatic and personally salient events such as diagnosis of HIV seropositive status and bereavement have identified relationships with both immunological and clinical indices of HIV progression. Kemeny, Weiner, Taylor, Schneider and others (1994) found that measures of grief uncomplicated by depression predicted reductions in immune function over a 2 to 3 year period in a group of seropositive gay men. This finding was replicated by Kemeny and Dean (1995) in which guilt and self-reproach or blame as an aspect of grief following bereavement predicted CD4+T cell declines during an 18 month period. However, other research indicated that actively confronting such traumas as bereavement or the threat of mortality and finding a sense of meaning could mitigate immunosuppression and mortality. For instance, Bower and Kemeny (1998) found that those who discovered meaning experienced a slower decline in CD4+T cell levels over 2 to 3 years and had an enhanced survival time during 4 to 9 years.

Defensive denial of seropositive status (Ironson, Friedman, Klimas, Antoni et al, 1994) and shame based concealment of homosexual identity were associated with immunosuppression and heightened risk of progression to AIDS during a 2 year follow up. These findings confirmed those of the earlier studies which had demonstrated significant associations between such factors, high risk sexual behaviour, immunosuppression and disease progression while linking acceptance of sexual identity with a lower probability of exposure to HIV and a more favourable prognosis. A matter of serious concern for health professionals working in the HIV/AIDS field (Todd, 1992).

Cole and Kemeny (1996;1997) investigated concealment of homosexual identity as a

model of what they termed 'psychological inhibition', finding accelerated times to a critically low CD4+T cell level as well as AIDS onset and mortality among 'closeted' members of a sample of initially healthy gay men followed up for a period of 9 years. The so-called 'closeted' individuals were assessed as particularly sensitive to perceived social rejection, this factor being an even stronger predictor of HIV disease progression than concealment per se. Such data seem to fit well with the notion of internalized homophobia with its associated shame and self hatred resulting in both concealment and perhaps through projection, hypersensitivity to rejection by others. As I shall discuss in the conclusions to this paper, the menace to mental and bodily health is homophobia which could be targeted in both individual and group interventions promoting self-acceptance as a step towards reducing high risk behaviour and disease progression.

To summarise, well controlled studies have implicated the following psychosocial factors as predictors of behaviour placing individuals at risk of HIV infection, and prone to immunosuppression, illness and AIDS mortality. The factors which can be considered to be potential foci for psychological interventions include: (a) depression, (b) bereavement (c) such grieving responses to bereavement as guilt and self reproach, identified by Freud (1917) in his paper on mourning and melancholia, as repressed feelings towards the deceased, (d) denial of such traumatic realities as seropositive status and mortality, (e) concealment rather than acceptance of sexual identity (f) internalized homophobia and (g) a sense of meaning in life in the face of the threat of mortality.

### **Interventions**

Kiecolt-Glaser and McGuire (2002) have provided a review of psychoneuroimmunological studies relevant to the understanding and treatment of cancer and autoimmune disease as well as HIV/AIDS. With respect to HIV, the authors paid specific attention to the potential benefit of psychological interventions as di-

verse as hypnosis, cognitive behaviour therapy, self-disclosure and existential approaches concerned with the quest for meaning in confronting such highly traumatic events as bereavement and mortality. In general terms they noted that the narrower the scope of a behavioural intervention and the shorter its time course, the smaller and less enduring would be its impact either psychological or immunological while observing that longer follow-up periods would be desirable in future evaluative research. Similarly, Cole et al (2001) had observed that several randomized clinical trials had suggested that psychological interventions addressed, for instance, to bereavement, grief and shame based concealment of sexual identity, may influence immunologic indices of disease progression. While Kiecolt-Glaser et al observed that intervention work with HIV seropositive persons had produced some 'promising results', this conclusion appears to have been based more upon the mounting evidence that psychosocial factors are significant predictors of behaviour exposing people to HIV infection and both immunity and disease progression than the results of well controlled intervention studies. Such research, however, would establish more of an empirical evidence base for psychological interventions as well as clarifying those with greater efficacy in reducing morbidity and mortality.

### **Conclusions**

In conclusion it may be useful to highlight the need for sophisticated studies of multiple variables in psychosocial research, permitting the use of such multivariate techniques as hierarchical logistic regression and discriminant function analyses, unresolved methodological issues and future directions for research. The variance accounted for as well as statistical significance levels need to be made explicit in such work relevant to interventions. The need for further prospective, longitudinal studies and controlling for such confounding variables as substance misuse and stage of illness at the commencement of research, with the larger sample sizes necessary to optimize statis-

tical power than those in cross-sectional and pilot work has been noted as important for more rigorous hypothesis testing and the provision of a solid evidence basis for interventions (Solomon, 1991; Todd, 1992; Cole & Kemeny, 2001). The simultaneous analysis of psychosocial factors, biological mediators and HIV disease progression remain important questions for research.

Psychological interventions would need to focus upon the modification of psychosocial factors demonstrated to be significant predictors of deleterious behaviours as well as immunity and disease progression in HIV seropositive persons. Such implicit or unconscious factors as denied or repressed homophobia and underlying negative emotions including anger, shame, guilt and reproach attributed to the person's own self may need to be further evaluated in the context of evaluating the efficacy of interventions. The empirically demonstrated significance of such implicit or unconscious factors could suggest that psychodynamic insights and techniques may need to be integrated into intervention programs in conjunction with other therapeutic modalities such as CBT. Reactions to bereavement, for instance, may also need to take into account the quality of the attachment to the deceased and whether the loss results in the emergence of conflicts and feelings about past losses of significant figures. Well designed evaluation studies could be considered vital to creating an empirically solid case for properly funded psychological intervention programs, independently of antiretroviral drug treatment. Cross cultural validation of research conducted in the developed world would permit generalization of results.

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## MY EXPERIENCE WORKING WITH TRANSGENDER CLIENTS

PAUL MARTIN

In over 15 years of private practice specialising in working with GLBT clients, I've worked with a number of transgender clients. What follows is a personal account of some of the issues I've encountered working with this population.

For each person I've worked with, I've realised I need to expect the unexpected. I've been amazed at the strength, fortitude and resilience of some of these clients, and worked with others who I've felt have struggled somewhat due to personality disorders and other issues, rather than issues related to their non-normative gender *per se*. There do, however, appear to be some experiences that are shared by all of the clients I have worked with. I will now summarise these similarities in the remainder of this commentary.

Working with several older transgender clients who are now in their late 50's, I have often noticed a sense that they have been pioneers with no real reference points or role models and that they had to almost make it up as they went along. Some of their stories have taken them across the globe in search of transgender surgery and many have encountered all sorts of horrendous physical and psychological distress as a result. The clients I have worked with seemed to have gained much from these experiences. I have found though that for some there is enduring psychological damage in response to years of relentless and significant hurt, rejection and social isolation.

Some of the female clients I have seen have worked very hard at altering the many nuances required to be perceived as a straight or lesbian woman and have been quite successful in this identity. However, for some of

these women I have witnessed an underlying sadness, which in part appears to be connected to not having had children whilst knowing they would have made a wonderful mother. Many of the heterosexual women I have worked with have also experienced the inevitable conflicts and rejections around 'coming out' as transgender when forming relationships with straight males. I have also noticed a significant amount of violence that some of these clients have endured in their lives.

Dealing with misunderstanding and rejection is often a daily challenge for some of my clients, particularly those who are transgender. Unfortunately, this has not solely been caused by heterosexual people, but has also occurred within GLBT communities. For some reason, many gay men and lesbians don't seem to connect with my transgender clients. This may perhaps be a combination of an unconscious belief that there must be something 'disordered' about a 'tranny', and that they therefore do not deserve to be taken seriously. There is also a sense that transgender people are incorrectly perceived as drag queens. As a result, some of my transgender clients have not felt that they belong to GLBT communities, believing they would be automatically rejected. Furthermore, some of my clients who identify as straight females have seen being part of the GLBT communities as being irrelevant. However, for some they also don't feel they fit into the straight community either, and have struggled to gain heterosexual or homosexual friendships or social connections. Some of my clients felt they would find 'their tribe' in the transgender community, but expressed a disappointment with some of their experiences in that community.

So whilst some of my clients would be more than able to be a wonderful potential friend, through their own issues and other's perceptions can end up isolated and unhappy.

Dealing with employment challenges has also been a significant issue for some of my clients. Some of my older clients found that the only options open to them were in the entertainment, prostitution and other underground areas. These environments for some seemed to include dealing with exploitation and violence. However, some of my younger clients have experienced some employers who genuinely care about inclusion and diversity and make a genuine effort. One of the lesbian psychologists in our practices has worked with transgender people regarding issues in the workplace. This has often involved identifying and modifying specific behaviours that are perceived by colleagues in the workplace as aggressive. This opens the door for many interesting discussions on the unconscious and conscious difference in gender expectations and behaviour.

For the female to male clients I have worked with there are just as many complexities. A couple of my preoperative clients have experienced difficulties with wanting to become pregnant. They have had to deal with the many challenges that have resulted from other people's negative reactions to this concept. This has included their doctors, potential donors who believe the child would be too confused and pull out at the last minute, and the challenges with having to cease hormonal treatment to aid the pregnancy and risk aging as a male.

The clients I have worked with who started hormonal treatment at a young age have aged in a way consistent with their chosen gender. The clients who have done so at a later stage in life have the aging characteristics of their original gender which they have found to be distressing as for these people it is often more difficult to seem like a straight woman or man, rather than being perceived as a 'tranny', a term often used in pejorative ways.

When I first started working with transgender clients I found myself having to identify my own internal irrational beliefs about these clients and found supervision to be very useful. In the early days, it took me some time to adapt to some of the complexities and confusions I had. For example, when doing some reprocessing work using schema therapy with a woman, I had to be careful to not confuse the both of us when going back to her childhood memories as a boy. I particularly had to be careful of not confusing genders when using past and present tense to demonstrate my own level of comfort in dealing with transgender issues. As such, I found that being open and aware of all of my emotional and underlying beliefs and challenging these constantly was essential.

Overall, I'm often left with a slight feeling of sadness after working with a transgender client, knowing they have made wonderful progress and will no doubt experience a higher self esteem, greater confidence and happiness, but at the end of the day I'm always aware of the other people out there who, no matter what, seem to have a real block around developing meaningful connections with transgender people. So many of my transgender clients, however, have shown me personally what can be achieved in life, no matter what the seemingly unsurmountable challenges.

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## BOOK REVIEW

BEN WALKER

*Safe, Sane and Consensual: Contemporary Perspectives on Sadomasochism. Edited by Darren Langdridge and Meg Barker. Hampshire: Palgrave Macmillan, 2007, 310 pp., ISBN-13: 978-0-230-51774-5 hardback.*

Safe, Sane and Consensual presents some of the latest research and analysis tackling the controversial area of sadomasochism. Such research is important as the DSM IV still lists SM as a disorder. Consequently, there is currently a movement to remove SM as a disorder in the next edition of the DSM.

Similar to the progression of the 'coming out' of homosexuality into the mainstream, the SM community is gradually coming out and thus is increasingly visible within society. A number of studies estimate that approximately 5-10% of the American population practice some form of SM, and mainstream artists such as Britney Spears and Madonna are incorporating SM aesthetics into their film clips. Even corporations such as IKEA have utilised SM sensibility in their advertising. Unsurprisingly, the place where SM practitioners are most 'out' is in San Francisco where the annual Folsom Street Fair attracts thousands of spectators.

However, the authors of Safe, Sane and Consensual describe that despite some acceptance of soft SM to 'spice up your love life', there is still much negativism toward regular SMers. This is especially regarding practices of a more hardcore nature that may leave temporary and sometimes permanent traces on the body. The primary issue is the concept that inflicting pain on others is violent and wrong. Many would perceive that while there is an obvious distinction between those who

engage in sadism and, for example, serial killers, ultimately sadism locates SM practitioners on the same continuum. In terms of masochists, the issue for many is a heartfelt feeling that they are being taken advantage of. Either the practice is not consensual, or it is consensual, but it is felt by some that there is something deeply wrong with a masochist seeking out pain inflicted upon them by a sadist.

Consequently, Safe, Sane and Consensual fills a gap in the existent academic literature in reporting studies of SMers' experiences as well as writings by practitioners themselves. For example, one 'top' (sadist in the SM pair as opposed to the masochist 'bottom') describes how SM is a fantasy where the pair are role-playing. The bottom describes the experience they desire to the top, and then the top lovingly creates that experience for them. Sophia writes "when I do top ... I think that the thrill of taking someone where they want to go and then bringing them back again safe and happy is too beautiful for words". The primary pleasure of the bottom seems to be in letting go and allowing someone else to take charge. For example, Grant Denkinson discusses how "I craved the creation of a safe space where I could lose control". One bottom writes that having masochistic experience actually makes them feel more confident and in control in the rest of life.

One of the most interesting sections of Safe, Sane and Consensual is on the relationship between SM and therapy. Henkin writes about "doing therapy in the dungeon". If a fantasy is not enacted then "the fantasy goes around and around in one's mind ... and the person remains stuck in the repetitions. When the

person brings the fantasy into real time and explores it with another person, however, the interaction can open some doors of perception". Easton also writes from a Jungian perspective of SM allowing people to explore their shadow side of their self to give them a more complete experience of life.

In regard to SM as a practice of therapy, my main critique of *Safe, Sane and Consensual* is that there is no mention of Cognitive-Behavioural Therapy (CBT) within the therapy section. Cognitive-Behavioural Therapy is the primary empirically based therapy at present, and I believe it is essential to integrate the two disciplines (no pun intended) if SM is to gain mainstream respect within the psychology profession. Confusingly for those unfamiliar with psychological terminology, but familiar with SM, CBT in the book refers to "cock and ball torture", which is torture of the male genitals. Cognitive-Behavioural Therapy is very practical in orientation by making behavioural changes in people's everyday life and changing their thinking on certain issues. One of the key behavioural changes encouraged is becoming more assertive and improving self-esteem, therefore integrating this understanding with a positive appraisal of SM is worthy of investigation.

Whilst I consider myself very open to alternative sexualities and practices, there are two issues discussed in the book that I have some difficulty accepting and would like to see developed in future research and theoretical analysis. The first is the more hardcore SM practice where people are consensually bled, scarred, set alight and left with permanent markings. One chapter describes how "[the appellants] branded a man 'A' with Laskey's initials using a wire heated by a blow lamp. Scarring from these injuries remains. Matches were taped to the victim's nipples and the navel and having been set alight were then doused". My intrinsic opposition to violence leads me believe that there is a line somewhere where even if the activity is consensual then it is neither safe nor mentally healthy. The second issue is the psychological health of

more permanent SM relationships. As an empiricist, I am open to the evidence, but my inclination is that somewhere in the sand there is a line where more hardcore SM practices or more permanent SM relationships are not safe even if consensual.

Overall though, an eye-opening and erudite book that explores a relatively unexamined area from a theoretical perspective, despite the growing numbers openly confessing to engaging in SM practice. If the findings that 5-10% of Americans practice SM is correct, then more research is necessary as part of a movement to understand SM. It could be helpful from the perspective of understanding existing practices as well as facilitating therapy where useful and perhaps even removing SM from the next edition of the DSM.

### **Author Note**

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## BOOK REVIEW

DAMIEN W. RIGGS

*David M. Halperin. (2005). What do gay men want: An essay on sex, risk, and subjectivity. Ann Arbor: University of Michigan Press, 167 pp., ISBN: 0472116223.*

I want to begin this review by stating clearly that this book is truly a wonderful read. David Halperin crafts, in a relatively short space, a wonderfully clear and exciting argument for new ways in which we may understand gay subjectivities, and more specifically, how we may understand gay subjectivities as shaped in a relationship to HIV/AIDS. As he so rightly points out, serostatus is of course not the only point of difference that shapes the lives of gay men, but his text nonetheless serves to remind the reader that it is unlikely to be the case that HIV/AIDS as a disease and as a point of social inquiry will go away in the near or even distant future. Understanding how it shapes the lives of gay men and how it plays a role in the shaping of our subjectivities is thus highly important. Yet despite the imposing role that HIV/AIDS plays in the lives of gay men, Halperin goes to considerable lengths to work up an account of gay subjectivities that refuses the interiorisation or individualisation of supposedly 'risky' behaviours, and in so doing refutes the notion that they are attributable to the 'unconscious drives' of gay men, either as individuals or as a collective.

Instead Halperin, drawing upon the concept of abjection, provides an account of gay subjectivities that sees them formed in a relationship to social norms around sexuality (and in particular prohibitions on gay sex and constructions of gay men as pathological or deviant), and in so doing he demonstrates how gay subjectivities exceed these social norms, or

more precisely, how gay men may choose to celebrate alternate visions of life, loss, love and community. Whilst providing a keenly theoretical account of abjection, Halperin also provides a clear outline of how the concept of abjection may function in the service of HIV transmission prevention by encouraging not only open discussion about serostatus, but also by shifting our attention, at least in part, away from particular bodies and their serostatus, and back to HIV itself: Halperin, or so at least it seemed to me, speaks against HIV as a disease at the same time as he speaks for (in the productive sense) both HIV positive and negative gay men. Such an account is exciting not only for the possibilities it holds for generating new forms of prevention campaigns, but also for the possibilities it opens up for new understandings of gay subjectivities.

Interestingly, however, the path that Halperin takes in order to get to his account of gay subjectivities is perhaps unnecessarily shaped by a critique of psychoanalysis (and to a lesser degree psychology). Whilst I share Halperin's concerns about the pathologising and internalising aspects of the mental health professions, I am not sure that critiquing certain aspects of them and then generalising them to entire disciplines is the best way forward, and certainly in places Halperin seems to acknowledge that there is a risk inherent to taking on this task. The reason why I mention my uncertainty about what is a very limited critique of psychoanalysis is that I don't think the critique was actually necessary to Halperin's argument. He does a wonderful job of outlining why an account of gay subjectivities is necessary, and how the particular ways that public

and academic moral panics about barebacking have served to revive pathological accounts of gay men, and to me this would lead clearly into a reformulated account of gay subjectivities that focuses on abjection: I am not sure that this pathway needed to be routed through a critique of psychoanalysis. Certainly much of what Halperin says about particular segments of psychoanalysis are correct, but focusing only on these segments serves in many places to overwrite some of the exciting aspects of psychoanalysis itself and what it may have to contribute to the theorisation of gay subjectivities in non-internalising and non-pathologising ways (see Riggs, 2008, for more on this). In other words, and as Halperin so rightly suggests, queer accounts of gay subjectivities are necessary for the ways in which they refuse to accept normative binaries of good and bad, yet this is something that I think could incorporate, rather than reject outright, psychoanalysis and its possible contribution to this agenda.

This concern aside, Halperin's text is a model not only for the ways in which it elucidates complex concerns over gay men's health and sexual practices in a very accessible and readable manner, but also for the ways in which it models a way of doing location as a writer. Halperin undertakes an incisive reading of a paper by Michael Warner, in which Warner speaks of notions of 'risk' and his own engagement as a gay man in unprotected anal intercourse. Whilst aspects of Halperin's extensive analysis of Warner's writing in places could have been a little more generous about psychoanalysis (or more precisely, have spent less time on psychoanalysis, as Warner's text - which is reprinted in full by Halperin - doesn't appear to actually warrant the attention to psychoanalysis that it is given), it nonetheless serves as a wonderful example of how to do disclosure as an author.

To elaborate: whilst Halperin writes clearly as a gay man throughout the book, he does not write clearly as either an HIV positive or negative man. In some contexts this would seem an unusual move, as it doesn't position

Halperin as invested in a particular position on HIV. Yet, as I suggested above, such a position is unnecessary as Halperin is neither arguing for or against particular HIV positive or negative gay men, but rather for an elaboration of gay subjectivities more generally. What Halperin does engage in, however, is the positioning of himself as a sexual being - as someone involved in the communities of which he writes, namely those in which gay sex is a matter of importance, pleasure and contestation. He achieves this not through clear disclosures (as is the case in Warner's piece), but rather through stylistic asides in the text, where he presents a particular formulation of gay sex or subjectivities or their relationship to HIV/AIDS, and then offers one-liners as stand alone paragraphs that provide personal comment on these formulations, such as "especially since sex without condoms is fun" (p. 24) and "in fact, when it comes to sex, five minutes can be a long time" (p. 40). Comments such as these, in addition to cleverly locating Halperin's own subjectivity as a gay man within the text, serve as salient reminders as to why the issues under examination are so complex and in such need of ongoing examination.

Finally, I was particularly taken not only by Halperin's thorough examination of the current literature on barebacking (and in particular its scare tactics and misrepresentations), but also his attention to the specificities of gay sex. Far too often I read work that fails to adequately locate the racialised or classed nature of much writing on gay men, factors that are important when considering sex between men. Whilst Halperin, through his theorisation of abjection, provides an account of 'gay subjectivities' in the plural, he is nonetheless clearly mindful of the specificities of gay subjectivities. Such an approach is vital in regard to any attempts at understanding what it is that gay men want (the central concern and title of Halperin's text), and indeed gain, from engaging with one another sexually, particularly when intercourse bridges divides of serostatus and social status (see Riggs, 2006, for more on this in regards to race privilege and seroconversion

narratives).

To conclude, then, despite the few concerns I have raised about the undue emphasis upon psychoanalysis and a tendency toward being somewhat less than generous about its possible role in understanding gay subjectivities in non-internalising and non-pathologising ways, Halperin provides us with an exciting and challenging examination of what gay men want. By outlining how gay sex is repeatedly pathologised, and by then moving on to outline how this pathologisation can not only be resisted, but indeed incorporated into modes of resistance, Halperin opens new avenues for investigating, theorising and living gay subjectivities. Halperin takes many stale debates and turns them on their heads, precisely by (for the most part) refusing the very terms on which they are set, and instead setting new terms that centre upon gay praxis. I look forward to using this text in my own ongoing explorations of gay subjectivities and also know that it has shaped my own engagements as a gay man.

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## BOOK REVIEW

ASHLEY VAN HOUTEN

*Head over heels: Wives who stay with cross-dressers and transsexuals. Virginia Erhardt, PhD. New York: The Haworth Press, 2007, 233pp., ISBN 0-7890-3095-0.*

The book is comprised of the stories of the wives of men who are cross-dressers and transsexuals. There are 30 stories of women finding out and coming to terms with their partners who are cross-dressers or transsexuals. The stories told from this perspective provide a unique insight into the lives and reactions of significant others in this complex and little understood area of human diversity. The Forward to the book provides the background to the inspiration for the book, emphasising the historical neglect in providing a voice and support services for significant others of cross-dressers and transsexuals.

The introduction offers an understanding of some of the varied challenges faced by significant others in living with a cross dresser or transsexual. The author's notation that cross-dressers also experience many negative consequences such as fear, self loathing, shame and depression highlights some of the difficulties cross-dressers experience. This emphasises the point that cross-dressing and transsexualism has with it serious consequences and is not something that someone would simply choose as a lifestyle.

Chapter two is titled "Transgender 101", and is meant to present explanations of some of the themes and issues of cross-dressers and transsexuals which include sexual orientation, gender identity, and gender role presentation. These explanations are useful to the lay reader to place the subject matter in a con-

text.

Through the narratives we see the many challenges wives of cross-dressers and transsexuals encounter. The short stories capture the many emotions experienced by these significant others such as shock, anger, disbelief, fear, disappointment, loss and confusion.

The strength of the book lies in its unique perspective, indicating through the narratives how the wives deal with the many challenges. The stories highlight what some wives found helpful and what others found not helpful. The book provides a voice of hope for couples and families facing similar challenges. The fact that the wives of cross-dressers and transsexuals remain committed to their relationships offers hope that these relationships can survive the challenges.

The resource list at the back of the book would be useful in highlighting the specific support groups and organisations that exist for the transgendered community and their significant others. While the resource list is specific to the USA, transgendered individuals and their significant others may use the book and its guide to seek assistance from similar organisations in their own countries. The glossary of terms would also be useful for significant others, clinicians and researchers who may get confused by the specific terminology and may unwittingly offend the transgender community through the inappropriate use of terminology.

The 30 stories are concise, offering a quick glimpse into a complex and often controversial area. While the brevity enables quick reading

and a diversity of stories, the concise nature of the stories can serve to minimise what is a very complex and distressing set of concerns for the individuals involved. At the end of each story the author has attempted to provide a brief interpretation of each story. Unfortunately, the brevity of the interpretation appears in places to minimise the distressing experiences of these women. Some of the conclusions drawn about possible other diagnoses from such a concise account may be viewed as lacking in providing the need for a thorough collaborative approach to assessment, diagnosis and treatment.

While the book offers some explanation of the themes of cross-dressers and transsexuals, its juxtaposition of these two distinct categories may be confusing. The two are distinctly different. Cross-dressers are classified under the paraphilias under the subsection name 'transvestic fetishism' in the DSM, whilst transsexualism is a separate diagnosis of Gender Identity Disorder. Placing the two together may perpetuate the confusion that exists that the two conditions are related.

Nonetheless, the book would be useful to significant others of cross-dressers and transsexuals in normalising their experience and providing them with a basis from which to anchor further support.

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## Preparation, submission and publication guidelines

Types of articles that we typically consider:

A)

Empirical articles (6000 word max)  
Theoretical pieces  
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B)

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Each submission in section A should be prepared for blind peer-review if the author wishes. If not, submissions will still be reviewed, but the identity of the author may be known to the reviewer. Submissions for blind review should contain a title page that has all of the author(s) information, along with the title of the submission, a short author note (50 words or less), a word count and up to 5 key words. The remainder of the submission should not identify the author in any way, and should start on a new page with the submission title followed by an abstract and then the body of the text. Authors who do not require blind review should submit papers as per the above instructions, the difference being that the body text may start directly after the key words.

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Journal Articles: Riggs, D.W. (2004). The politics of scientific knowledge: Constructions of sexuality and ethics in the conversion therapy literature. *Lesbian & Gay Psychology Review*, 5, 16-24.

Books: Kitinger, C. (1987). *The social construction of lesbianism*. London: Sage.

Edited Books: Coyle, A. & Kitinger, C. (Eds.) (2002). *Lesbian & gay psychology*. Oxford: BPS Blackwell.

Book Chapters: MacBride-Stewart, S. (2004). Dental dams: A parody of straight expectations in the promotion of 'safer' lesbian sex. In D.W. Riggs & G.A. Walker (Eds.), *Out in the antipodes: Australian and New Zealand perspectives on gay and lesbian issue in psychology* (pp.393-416). Perth: Brightfire Press.

References within the text should be listed in alphabetical order separated by a semi-colon, page numbers following year. For example:

(Clarke, 2001; Peel, 2001; Riggs & Walker, 2004)

(Clarke, 2002a; b) (MacBride-Stewart, 2004, p. 398)

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